JUNE, 1961

RHODE ISLAND

Medical Journal

Volume XLIV, No. 6

Table of Contents, page 315

With proper medical management and adequate control of seizures, epileptic persons may lead productive, functioning lives.[1,2] To implement this goal, many clinicians rely on DILANTIN for outstanding control of grand mal and psychomotor attacks. "In most cases DILANTIN is the drug of choice.... Toxic symptoms are uncommon and when they do appear they are usually readily controlled; the drug is inexpensive, and widely available."[3] DILANTIN Sodium (diphenylhydantoin sodium, Parke-Davis) is available in several forms, including Kapseals, 0.03 Gm. and 0.1 Gm., bottles of 100 and 1,000.

other members of the PARKE-DAVIS FAMILY OF ANTICONVULSANTS for grand mal and psychomotor seizures: PHELANTIN® Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100. for the petit mal triad: MILONTIN® Kapseals (phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000; Suspension, 250 mg. per 4 cc., 16-ounce bottles · CELONTIN® Kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100. ZARONTIN® Capsules (ethosuximide, Parke-Davis) 0.25 Gm., bottles of 100. See medical brochure for details of administration and dosage.

DILANTIN®
SODIUM KAPSEALS®
HELPS KEEP HIM IN THE MIDST OF THINGS

51061

(1) Carter, S.: *M. Clin. North America* 37:315, 1953.
(2) Maltby, G. L.: *J. Maine M. A.* 48:257, 1957.
(3) Crawley, J. W.: *M. Clin. North America* 42:317, 1958.

PARKE-DAVIS
PARKE, DAVIS & COMPANY, Detroit 32, Michigan

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY

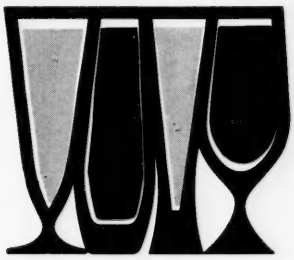
Second-class postage paid at Providence, Rhode Island

Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLIV, No. 6 **June, 1961**

TABLE OF CONTENTS

introducing...nutritional support in convenient, tasty, liquid form to supplement inadequate diets... to replace skipped meals



Nutrament T.M.

BRAND

nutritionally complete food

a nutritious meal, ready to drink

nutritional support is often needed for:

careless or irregular eaters—who skip breakfast or lunch or do not eat properly because of busy schedules or faulty eating habits.

children—who need increased basic nutrients during convalescence[1] or during difficult feeding periods, such as after tonsillectomies.[2]

adolescents—who require nutritional support because of growth needs and poor dietary selection.[3]

pregnant patients—who often require sound, easily tolerated, and convenient nutritional supplementation during pregnancy and lactation.[4]

geriatric patients and others—who cannot or will not maintain proper nutrition because of poor dentition, faulty eating habits, or lack of interest in eating.[5]

hospital patients—Nutrament liquid can serve as an excellent and convenient source of nourishment.

and in Oral, Dental or Surgical conditions—which interfere with or prevent consumption of solid food.

readily accepted by patients

Nutrament liquid requires no special preparation. Smooth texture and appealing taste of Nutrament make it readily acceptable. Equally delicious served hot or cold. Nutrament also has a high satiety value.

supplied

In 12½ fl. oz. cans, chocolate and vanilla flavors. Conveniently available at drug and food stores.

offers a scientifically balanced ratio of carbohydrate, protein, and fat. Each 12½ fl. oz. can of Nutrament liquid provides 400 calories. Caloric distribution: protein–20% (20 Gm.); carbohydrate–50% (50 Gm.); fat–30% (13.3 Gm.); plus the following vitamins and minerals:

		% MDR		
Vitamin A (U.S.P. Units)	1250	30	Vitamin E (Int. Units)	2.5
Vitamin D (U.S.P. Units)	125	30	Pyridoxine, mg.	0.4
Vitamin C, mg.	50	166	Vitamin B_{12}, mcg.	0.5
Thiamine, mg.	0.5	50	Calcium pantothenate, mg.	2
Riboflavin, mg.	0.6	50	Sodium, Gm.	0.2
Niacinamide, mg.	5	50	Potassium, Gm.	0.9
Calcium, Gm.	0.5	67	Copper, mg.	0.5
Phosphorus, Gm.	0.4	53	Manganese, mg.	1
Iron, mg.	4	40	Fiber, Gm.	0.55
Iodine, mcg.	60	60		

ingredients: Whole milk, skim milk, sugar, soy flour, Dextri-Maltose® (maltose and dextrins derived from enzymic action of choice barley malt on selected corn flour), starch, chondrus extract, sodium alginate, vitamin A palmitate, calciferol, sodium ascorbate, thiamine hydrochloride, niacinamide, ferrous sulfate, sodium iodide, *d*-alpha-tocopheryl acetate, pyridoxine hydrochloride, cyanocobalamin, calcium pantothenate, salt, cupric carbonate, manganese sulfate, cocoa and/or imitation vanilla flavor.

references: (1) Nelson, W. E.: Textbook of Pediatrics, ed. 7, Philadelphia, W. B. Saunders Company, pp. 231-233, 1959. (2) Parrott, R. H., and Nelson, W. E.: *ibid.*, p. 759. (3) Johnston, J. A.: Ann. New York Acad. Sc. *69*:881-901 (Jan. 10) 1958. (4) Burke, B. S., and Kirkwood, S. B., in Greenhill, J. P.: Obstetrics, ed. 12, Philadelphia, W. B. Saunders Company, 1960, pp. 126-131. (5) Skillman, T. G.; Hamwi, G. J., and May, C.: Geriatrics *15*:464-472 (June) 1960. 57061

Edward Dalton Co.
A DIVISION OF
MEAD JOHNSON & COMPANY

Quality products from nutritional research

TIME DISCUSSES THE ANATOMY OF ANGST

In the U.S. today, causes for . . . Weltschmerz are easy to find. Psychologists know that all change is threat and that all threat produces anxiety. The U.S., more than any other society in history, believes in change. Conservative in many ways, the U.S. has never been conservative in the sense of trying to preserve things the way they were yesterday. Its very orthodoxy is based on the idea of change: the most orthodox tenet in the American creed is that the individual can accomplish anything if he tries hard enough. It may be one of the glories of a free society, but it also carries great potential danger and may well be the greatest single cause of anxiety on the American scene. From the noble notion that man is free to do anything that he can do, the U.S. somehow subtly proceeds to the notion that he must do anything he can and, finally, that there is nothing he cannot do.

This leads to a kind of compulsory freedom that encourages people not only to ignore their limitations but to defy them: the dominant myth is that the old can grow young, the indecisive can become leaders of men, the housewives can become glamour girls, the glamour girls can become actresses, the slow-witted can become intellectuals.

Almost every boy in the U.S. has dinned into him the idea that he must excel his father — a guaranteed producer of anxiety, by Freudian theory, if the boy has grown up idolizing his father as a paragon of power and virtues. The process is severest in the sons of outstandingly successful men: their anxiety neuroses are as notorious as the traditional case of the preacher's son becoming a drunkard. A career girl is shredded by the need to excel father or mother or both, and for her the problem may be complicated by Oedipal feelings toward father.

Many people feel guilty simply about not being talented enough or intelligent enough or well-informed enough. If anybody can be anything he wishes, no wonder the businessman is made to feel guilty if he has neither ear nor taste for modern music (but somehow, the artist never seems to feel guilty about not understanding business). No wonder, too, that the adman thinks he ought to be able to write a novel or to know all about the atom. In an absurd misapplication of the idea of equality, one man's opinions become as valid as another's. Thus, every man competes not only in his own job or his own social setting: he also somehow feels he must compete with the TV newscaster and the editorial writer (not very difficult),* with the physics professor and the philosopher (very difficult indeed).

Every girl is tight-corseted with the propaganda that she must have a slim, svelte figure, no matter what her natural body build or bone structure. She may react to this either by trimming down mercilessly and suffering near starvation; or she may surrender to the neurotic pleasures of overeating—all the time rationalizing that the trouble is in her glands (which it almost never is). Another deliberate anxiety builder is the slogan, "Why grow old?" It introduces a prescription containing a teaspoonful of wisdom, such as the values of exercise and a balanced diet, diluted in an ocean of nonsense about wrinkle erasers and pep medicines. Actually, the less anxiety is associated with the inevitable aging process, the better are people's chances of growing old gracefully and with a sense of fulfillment.

The phenomenon of change in the U.S. contributes to anxiety in another way: no one "knows his place," and even if he does and likes it, there are no easy ways of announcing the fact to others. The worker can indeed still become boss, the immigrant a settled American. But how do they show their newly acquired place in life? No aristocratic titles, no rigid distinctions of dress are available; man's achievements can be signaled only by the fascinating game of displaying "status symbols." Hence the endless American preoccupation with what is "in" and what is "out"—clothes, addresses, speech, schools, cars . . . .

. . . Reprinted by permission from TIME, the weekly newsmagazine; copyright TIME Inc. 1961

*Underlining ours.

Check the date . . .

Wednesday, September 27, 1961

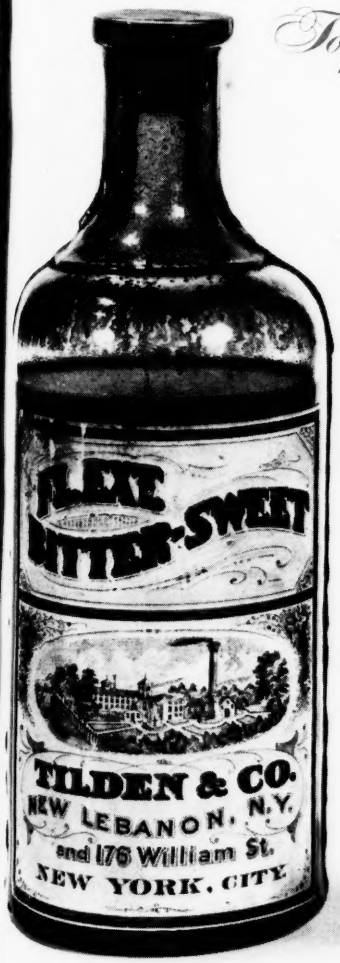
HOUSE OF DELEGATES MEETING

at 8:00 P.M.

1824 — 1961

A 137 year old tradition with Tilden...

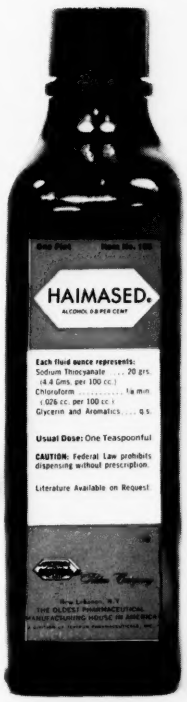
To provide the traditional, reliable pharmaceuticals most useful in your practice of medicine today



The First Fluid Extracts were made in the U.S.A., in 1848 by The Tilden Company, the oldest pharmaceutical manufacturing house in America. Founded in 1824.

HAIMASED®

the prescription of choice in essential hypertension



Lower blood pressure effectively...safely, with this time-tested Sodium Thiocyanate formula. The proved clinical record of Haimased for 27 years and more than 1,500,000 prescriptions shows this to be the therapy of choice over the newer, potentially more toxic Hexamethonium[1]-veratrum-rauwolfia preparations. A reduction of 30 to 50 mm. Hg in systolic pressure, without orthostatic hypotension, can be anticipated in 40-70% of patients.[2,3,5] Sympathectomy appears to increase the antihypertensive action of Haimased.[4,5]

DOSAGE: During the first five to seven days of treatment, 1 teaspoonful of Haimased (representing 2½ grains—or .16 Gm.—of Sodium Thiocyanate) well diluted in water, three times a day, is considered adequate to produce a blood concentration sufficient for a decline of elevated blood pressure and alleviation of symptoms associated with hypertension. Many clinicians prefer to start with one-half this dose and gradually build up until effect on blood pressure is noted and adequate blood levels reached. Since Haimased is a liquid, it permits fractional, easier adjustment of correct dosage. As the blood pressure approaches the estimated normal, the quantity must be gradually reduced to a maintenance dose of 1 teaspoonful of Haimased daily (2½ grains of Thiocyanate or .16 Gm.) over an extended period of time, without the development of secondary toxic effects. In certain patients, it may be best to interrupt medication for a period of one month after three or four months of administration. Reduced blood pressure levels may be maintained for many days after dosage is decreased or administration temporarily discontinued.

FORMULA: Palatable, stable, easy-to-take fluid. Each 100 cc. of Haimased represents 4.4 Grams (20 grains to the fluid-ounce) of Sodium Thiocyanate; alcohol 0.8% by volume; glycerine and aromatics q.s. No Sugars. **SUPPLIED:** in pint and gallon bottles.

CONTRAINDICATIONS: Thiocyanates should not be used in patients with congestive heart failure, easily provoked recurring attacks of angina pectoris, severe debility, nephritis, renal insufficiency, or cerebral damage. The dosage of Haimased should be decreased in the presence of extreme fatigue, vomiting, abdominal cramps, or diarrhea. Administration should be terminated immediately upon manifestation of such symptoms as exfoliative dermatitis, psychosis, and delirium, occurring occasionally with blood levels higher than 12 mg.

References: 1. California Medicine, 80:375, 1954; 2. Peterson, D. M.: J. Missouri S.M.A., 40:279, 1943; 3. Lindberg, H. A., Treger, N. V., Barker, M. H.: Quarterly Bull., Northwestern Univ. Med. School, 22(1):59, 1948; 4. Davis, L.: Postgraduate Med., 9:321, 1951; 5. Goodman and Gilman, The Macmillan Co., New York, 1958.

the Tilden Company NEW LEBANON, N. Y.

A DIVISION OF TEXTRON PHARMACEUTICALS, INC.

THE OLDEST PHARMACEUTICAL MANUFACTURING HOUSE IN AMERICA • FOUNDED 1824

THE WASHINGTON SCENE

A Report Prepared by the Washington Office of the American Medical Association

THE AMERICAN MEDICAL ASSOCIATION branded as untrue certain statements by Abraham Ribicoff, secretary of Health, Education and Welfare, concerning the administration's legislative proposal to provide medical care for the aged under Social Security.

Doctor F. J. L. Blasingame, A.M.A. executive vice president, presented a point-by-point rebuttal in a letter to the more than 500 editors from throughout the country after Ribicoff addressed the annual meeting of the American Society of Newspaper Editors in Washington.

Doctor Edward R. Annis, Miami surgeon representing the A.M.A., accused Ribicoff of misrepresenting the role of doctors under the administration proposal. Doctor Annis answered Ribicoff on a radio-television program with Senator Kenneth B. Keating (R., N.Y.) which was taped in Washington. Ribicoff had made the misrepresentation on an earlier Keating program.

Doctor Blasingame said Ribicoff's statement before the editors that physicians are not included in the administration proposal, the King bill, "simply is not true." The A.M.A. official pointed out that the bill includes interns and residents in teaching hospitals as well as pathologists, radiologists, physiatrists and anesthesiologists working in hospitals or serving hospitals' outpatient clinics.

"Mr. Ribicoff further claims that the King bill provides free choice of hospital physician," Doctor Blasingame said. "The fact is only hospitals signing contracts with the federal government would be available to patients. If the only hospital in a community was not approved by the secretary of HEW, patients in that community would be forced to seek hospitalization in some other city. That would not afford free choice of hospital. If the patient's physician was not on the staff of the other hospital, the patient would be denied free choice of physician."

Doctor Blasingame also disputed Ribicoff's contention that the King bill is not socialized medicine.

"By common definition, any scheme which calls for a system of compulsory health care which is administered, financed, and controlled by the federal government is socialized medicine for that segment of the population it serves."

Representative Walter H. Judd (R., Minn.), who is a physician, was quoted as one of a number of House and Senate members who agree with the A.M.A.: "The public has been led to believe that they can get government financing without government control and ultimate government operation of medical services. It is naïve for anyone to believe that Congress will take the people's money away from them through taxes and then allow the money to be spent by someone else without the Congress maintaining its own firm control."

Pointing out that the nation's physicians always have been in favor of medical care for all regardless of ability to pay, Doctor Blasingame said:

"It seems strange to us that Mr. Ribicoff continues to lobby for the King bill while completely ignoring the Kerr-Mills law, passed by Congress last year with strong support by the nation's physicians.

"The Kerr-Mills Law enables the states to guarantee to every aged American who needs help the health care he requires. And the states are implementing the law with unprecedented swiftness."

Doctor Annis pointed out on the radio-television program that "doctors would work for the government by working for the hospitals under contract to the government." He said those doctors would work "under rules, regulations and controls prescribed and laid down" by the H.E.W.

* * *

Krebiozen Evaluation

The Department of Health, Education and Welfare has agreed to make an impartial evaluation of the controversial cancer drug Krebiozen.

U.S. District Judge Julius H. Miner of Chicago requested the evaluation before proceeding with a $300,000 libel suit filed by Andrew C. Ivy, M.D., a leading endorser of the drug, against George D. Stoddard, PH.D., chancellor of New York University and former president of the University of Illinois.

In a letter to H.E.W. Secretary Ribicoff, Miner said:

"In my humble judgment, Krebiozen has too long been a controversial subject and the American public deserves that it be examined under neutral supervision and by the most competent experts in whom the people have implicit confidence."

continued on page 324

leads to visceral distress...

The uniformly dependable antispasmodic-sedative action of DONNATAL relieves hypermotility, hypertonicity and spasticity of smooth muscle **at all levels** of the gastrointestinal tract: pharynx, esophagus, stomach, small intestine and large intestine.

Donnatal incorporates **natural** belladonna alkaloids in optimal synergistic ratio, supplemented by phenobarbital in low dosage, for concurrent control of both somatogenic and psychogenic factors.

For dosage flexibility—

DONNATAL® TABLETS CAPSULES ELIXIR

Antispasmodic maintenance under a t.i.d. dosage regimen

Robins

For prolonged effects—

DONNATAL® EXTENTABS®

All-day or all-night spasmolytic benefits on a single dose, equal to the effect of one DONNATAL tablet uniformly sustained for 10 to 12 hours.

	In each Tablet, Capsule, or 5 cc. Elixir	In each Extentab
Hyoscyamine sulfate	0.1037 mg.	0.3111 mg.
Atropine sulfate	0.0194 mg.	0.0582 mg.
Hyoscine hydrobromide	0.0065 mg.	0.0195 mg.
Phenobarbital	(¼ gr.) 16.2 mg.	(¾ gr.) 48.6 mg.

DONNATAL® Robins

natural belladonna alkaloids with phenobarbital

Prescribed by more physicians than any other antispasmodic

A. H. ROBINS CO., INC.
RICHMOND 20, VIRGINIA

Making today's medicines with integrity... seeking tomorrow's with persistence

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

The Newport County Medical Society tendered a testimonial dinner at the Hotel Viking on May 10, 1961 to Samuel Adelson, M.D., newly elected president of the Rhode Island Medical Society. Doctor Adelson is the third member of the Newport County Medical Society to be elected president of the state medical society since its founding in 1811.

Those at the head table who paid tribute to Doctor Adelson were Banice Feinberg, M.D., of Providence, Captain Joseph Yon, commanding officer of the Newport Naval Hospital and Alfred Tartaglino, M.D., who presented an engraved gavel to Doctor Adelson on behalf of the local medical society. José Ramos, M.D., president of the Newport County Medical Society extended the congratulations and best wishes of the local society to Doctor Adelson on his election. Charles Dotterer, M.D., was toastmaster.

RICHARD R. KNOWLES, *Secretary*

WASHINGTON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Washington County Medical Society was held at the Larchwood Inn in Wakefield, Rhode Island, on April 12, 1961.

The meeting was called to order by the president, Doctor James McGrath, at 11:10 A.M.

The minutes of the January meeting as circulated to the membership were unanimously accepted without additions or corrections.

There was about a 25% response to the postcards requesting suggestions for the use of the society funds and these were read to the membership. A Committee was appointed to discuss the matter and report on their findings or ideas at the July meeting.

The following communications were presented: A poster from the American National Red Cross Blood Program on *Vaccinia Immune Globulin (V.I.G.)*; A communiqué from the State Department of Health was presented concerning the prevention of paralytic poliomyelitis. A lengthy discussion of the entire membership on this problem followed. Mr. John E. Farrell, executive secretary of the Rhode Island Medical Society, presented a brief outline of the problem as it was being handled by the Providence area; the newly proposed Lien Law in regard to doctors was discussed briefly and the membership was urged to write to ensure its passage, and the material from the American Medical Association regarding Medical Care for the Aged was reviewed and passed around to the membership. The membership was then advised to see that the proper information was disseminated where it would do the most good.

Reports from Committee meetings: Doctor McGrath stated that Doctor Agnelli would present the report from the Committee on Judicial Matters at the next meeting. Doctor Tatum as the chairman of the Committee formulating the history of the Washington County Medical Society presented a bill for fourteen ($14.00) dollars for typing expenses. A motion was made, seconded, and passed to make an allotment to pay the bill. Doctor Tatum then asked for some aid in outlining noteworthy events and/or happenings in the society since World War II.

New Business: Two new applications for membership in the society were presented and were passed by the censors. The membership voted to accept the new applicants as members. The two were: Phillip Neri, M.D., and Charles Farrell, M.D., associate member.

Motion for adjournment was made and seconded. The motion carried and the business meeting adjourned.

The meeting was then turned over to the guest speaker, Captain Louis Haynes, MC, USN, who presented an extremely interesting discussion on *Clinical Experience with Frozen Banked Blood.*

This paper was presented with accompanying slides to facilitate the presentation.

Guests at the meeting included: William Hetzel, M.D., and John Farrell, SC.D.

Respectfully submitted,
JOHN J. WALSH, JR., M.D.

THE WASHINGTON SCENE

concluded from page 320

Ribicoff said the National Cancer Institute would evaluate the drug when its sponsors presented the necessary data. But, he said, "any decision to undertake a study with human cancer patients must await, and depend on, the results of the evaluation of the existing clinical data."

* * *

Physicians' Retirement

A new bill to encourage physicians and other self-employed persons to set up their own retirement plans started through Congress with approval of the House Ways and Means Committee.

Bearing the same number, H.R. 10, as a similar bill which died in Congress last year, the new measure would permit a self-employed person to defer taxes on income placed in a private retirement program. The special treatment would be limited to $2,500 or 10 per cent of income each year, whichever is smaller.

Such income could be invested in qualified pension trusts, annuity programs, profit-sharing plans or a new type of nontransferable government bonds redeemable when the individual reaches retirement age or suffers disability.

An individual could start drawing benefits at age 59½, or earlier in the case of disability. A self-employed person would have to start drawing benefits by age 70½.

If a self-employed individual had more than three employees, he would be required to set up pension plans for them before he could benefit himself.

RIGHTS

". . . I cannot pass over the Democratic platform without commenting on the distortion of the word "right." For example, the platform mentions the right of every worker to a useful and remunerative job; the right of every farmer to a decent living; the right of every family to a decent home; the right of every child to a good education; the right of aged persons to adequate medical care.

"Are these rights? Certainly not. They are no more than targets on which a society sets its sights. All too frequently we try to achieve them through direct government guarantees rather than through individual initiative and enterprise stimulated by sound government leadership.

"The platform seems to say that every individual is entitled to the best of everything as a matter of right. Birth is the only qualifying condition. This is a dangerous philosophy. A nation is bound to deteriorate if the industrious, the strong, the creative and the self-reliant are forced, to the point of discouragement, to provide ideal living conditions for those who are not."

. . . EUGENE M. THORE, *vice president* and *general counsel*, Life Insurance Association of America, in an address at the 54th annual meeting of the Association.

APPOINTED COMMITTEES . . . 1961-62

THE RHODE ISLAND MEDICAL SOCIETY

Advisory Committee to R. I. Chapter American Physical Therapy Association

John H. Gordon, M.D., *Chairman*
Eric Denhoff, M.D.
Louis Sage, M.D.

Committee on Aging

Richard Kraemer, M.D., *Chairman*
Alex Burgess, Sr., M.D.
Charles D. Charon, M.D.
John F. W. Gilman, M.D.
Ezra Sharp, M.D.
Janis Gailitis, M.D.
Robert W. Drew, M.D.
Joseph McWilliams, M.D.
Rudy K. Meiselman, M.D.
Mark A. Yessian, M.D.

Blood Bank Committee

Gary Paparo, M.D., *Chairman*
George W. Anderson, M.D.
Enold H. Dahlquist, M.D.
Jacob Dyckman, M.D.
Leroy W. Falkinburg, M.D.
Herbert Fanger, M.D.
Stephen J. Hoye, M.D.
Henry J. Tweddell, M.D.
Erwin O. Hirsch, M.D.
John M. Malone, M.D.
William A. McDonnell, M.D.

Cancer Committee

Henry C. McDuff, M.D., *Chairman*
Edmund Billings, M.D.
George V. Coleman, M.D.
Herbert Fanger, M.D.
Arcadie Giura, M.D.
Hartford Gongaware, M.D.
Stephen J. Hoye, M.D.
Phillip Morrison, M.D.
Thomas Murphy, M.D.
Thomas Perry, Jr., M.D.
Robert F. Rosin, M.D.
George W. Waterman, M.D.
Simon Lenzner, M.D.
Emanuel W. Benjamin, M.D.

Child-School Health Committee

John T. Barrett, M.D., *Chairman*
Lewis Abramson, M.D.
John E. Farley, M.D.
Rudolph A. Jaworski, M.D.
Robert M. Lord, Jr., M.D.
Betty Mathieu, M.D.
Frederick A. Peirce, M.D.
William P. Shields, M.D.
Ruth Appleton, M.D.
Briand Beaudin, M.D.
Wilson Utter, M.D.
Oscar Dashef, M.D.
William L. Leet, M.D.
Lee G. Sannella, M.D.

Diabetes Committee

William Leet, M.D., *Chairman*
Rocco Abbate, M.D.
D. Richard Baronian, M.D.
Charles Does, M.D.
Louis I. Kramer, M.D.
A. Lloyd Lagerquist, M.D.
John J. Lury, M.D.
Kenneth B. Nanian, M.D.
Alton M. Paull, M.D.
Albert F. Tetreault, M.D.
Salvatore Turco, M.D.
Edward Zamil, M.D.
Thomas Murphy, M.D.
Amy Russell, M.D.
John M. Bleyer, M.D.
Peter Erinakes, M.D.

Disability Compensation Committee

Joseph C. Johnston, M.D., *Chairman*
Oswald Cinquegrana, M.D.
Joseph N. Corsello, M.D.
Thomas J. Dolan, M.D.
Americo A. Savastano, M.D.
Bencel Schiff, M.D.
Richard P. Sexton, M.D.
Stanley Sprague, M.D.
Joseph E. Wittig, M.D.
E. Arthur Catullo, M.D.
John J. Donnelly, M.D.
Henry Fletcher, M.D.
Anthony Verrone, M.D.

continued on page 330

Why Homer Jackson's work is important to you...

Talking on the radio-telephone is Homer "Bud" Jackson, both a scientist and a hard-working buyer for a company processing Florida oranges into frozen juice concentrate.

He has just made a decision that's important to you. He has analyzed some sample oranges from the grove in the background and found that they have the optimal amount of sugar, of acid, and are of the proper texture. (Testing for vitamin C comes later.) Homer Jackson knows that these oranges are of a quality to meet the exacting regulations required by the Florida Citrus Commission.

These standards for quality in citrus products are the highest in the world. This is important to you and your patients because juice made from the best oranges will be nutritionally best for your patients. It will contain abundant amounts of vitamin C and rich, natural fruit sugars.

It's good nutrition to encourage people to drink orange juice. It makes good sense to persuade them to drink orange juice that you *know* tastes good, has the right sugar-acid ratio, and is packed full of nutritionally important vitamin C.

APPOINTED COMMITTEES

continued from page 328

Advisory Committee to Woman's Auxiliary

Henri E. Gauthier, M.D., *Chairman*
John A. Dillon, M.D.
Earl F. Kelly, M.D.
Alfred L. Potter, M.D.

Disaster Committee

Francis E. Hanley, M.D., *Chairman*
James B. Moran, M.D.
G. Edward Crane, M.D.
Joseph E. Donahue, M.D.
Robert W. Drew, M.D.
J. Merrill Gibson, M.D.
William A. McDonnell, M.D.
Francis W. Nevitt, M.D.
Joseph L. Ruisi, M.D.
Alfred Tartaglino, M.D.
Frank A. Racioppi, M.D.
Stanley Freedman, M.D.

Federal Medical Services

Freeman B. Agnelli, M.D., *Chairman*
Thomas Perry, Jr., M.D.
Philomen P. Ciarla, M.D.
Arthur E. Hardy, M.D.
George W. Waterman, M.D.
Earl J. Mara, M.D.
Richard Sexton, M.D.
Auray Fontaine, M.D.
Michael DiMaio, M.D.

Highway Safety Committee

John A. Dillon, M.D., *Chairman*
Thomas C. McOsker, M.D.
Edward J. Butler, M.D.
Thomas Nestor, M.D.
Frederick Webster, M.D.
Taras Hanushevsky, M.D.
Robert E. Newhouse, M.D.
Julius Stoll, M.D.
Nathaniel D. Robinson, M.D.
H. Raymond McKendall, M.D.

Mental Health Committee

Harold W. Williams, M.D., *Chairman*
David J. Fish, M.D.
Charles C. Goodman, M.D.
Maurice Laufer, M.D.
Hugh Kiene, M.D.
Neida Q. Ogden, M.D.
Laurence Senseman, M.D.
Louis V. Sorrentino, M.D.
Hugo Taussig, M.D.
Joseph S. Zucker, M.D.
Oscar Stapans, M.D.

Maternal Health Committee

Stanley Davies, M.D., *Chairman*
Alfred L. Potter, M.D.
John E. Carey, M.D.
Francis V. Corrigan, M.D.
Walter J. Dufresne, M.D.
John A. Ferris, M.D.
William J. MacDonald, M.D.
William A. Reid, M.D.
Henry E. Turner, M.D.
Frederic W. Ripley, M.D.
Alvin G. Gendreau, M.D.
Guyon Dupre, M.D.
J. Kenneth Beezer, M.D.
Louis J. Fuhrmann, M.D.
Herbert Ebner, M.D.

Medical Advisory Committee to Polio Foundation

Raymond L. Trott, M.D., *Chairman*
Thomas L. Greason, M.D.
Clara L. Smith, M.D.

Perinatal Mortality Committee

Bertram H. Buxton, M.D., *Chairman*
William A. Reid, M.D.
George Anderson, M.D.
John Carey, M.D.
Francis V. Corrigan, M.D.
Eric Denhoff, M.D.
Herbert Ebner, M.D.
Thomas F. Head, M.D.
Gilbert Houston, M.D.
Rudolph Jaworski, M.D.
Maurice N. Kay, M.D.
Sumner I. Raphael, M.D.
Wilson F. Utter, M.D.
William McDonnell, M.D.

Committee on Prevention and Treatment of Athletic Injuries

Americo A. Savastano, M.D., *Chairman*
G. Edward Crane, M.D.
William J. Schwab, M.D.
Edwin B. O'Reilly, M.D.
Salvatore Turco, M.D.
Charles J. Hutchinson, M.D.
Joseph Donahue, M.D.

General Committee for Sesquicentennial

Thomas Perry, Jr., M.D., *Chairman*
Francis H. Chafee, M.D.
John T. Barrett, M.D.
J. Murray Beardsley, M.D.
Francis V. Corrigan, M.D.
Katharine Cutts, M.D.
Herbert Fanger, M.D.
Charles L. Farrell, M.D.

concluded on page 332

The extra-firm mattress selected by over 9,000 doctors for their own use

Assures both preventive and corrective support—used in more American homes than any other special design

Sealy Posturepedic is the first mattress designed in cooperation with leading orthopedic surgeons to promote normal, healthful sleep among *all* persons.

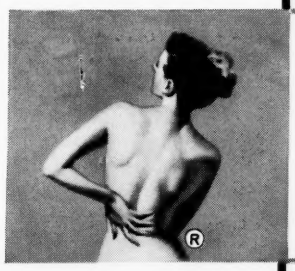
As a "corrective device" it serves those chronically afflicted with lower back syndromes. As a preventive measure Sealy Posturepedic brings deep spring buoyancy without bedboard hardness to everyone—plus the concomitant blessings of unexcelled comfort and extra-firm support.

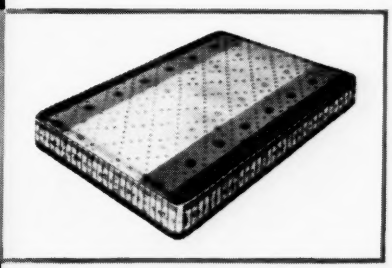
These are basic to good health. The therapeutic value of restful sleep is especially recognized during these tense and anxious days. Sealy Posturepedic eminently meets this need by supplying level spine support for proper relaxation of the limbs and human musculatory system.

Over 9,000 doctors of medicine have tried and bought the Sealy Posturepedic mattress and matching foundation for their own use. We believe your investigation will firmly convince you of its distinctive benefits, and, we would hope, merit your valued recommendation.

Sealy POSTUREPEDIC® BRAND

NO MORNING BACKACHE
from a too-soft mattress





PROFESSIONAL DISCOUNT OF $39.00

So that you may judge the quality of the Sealy Posturepedic for yourself, we offer a special Professional Discount on this mattress and foundation when purchased for your personal use. *Limit—one full or two twin size sets.*

SEALY MATTRESS COMPANY • Oakville, Conn.

Enclosed is my check and letterhead. Please ship the Sealy Posturepedic Set(s) indicated below:

1 Full Size ☐ **1 Twin Size** ☐ **2 Twin Size** ☐

	RETAIL		PROFESSIONAL
Posturepedic Mattress	each $79.50	(add state tax)	$60.00
Posturepedic Foundation	each $79.50	(add state tax)	$60.00

NAME_____

RESIDENCE_____

CITY_____ ZONE_____ STATE_____

(This is a saving of $39.00 per set over the regular $159.00 retail price for mattress and matching foundation)

APPOINTED COMMITTEES

concluded from page 330

Sesquicentennial (continued)

Ulysse Forget, M.D.
Henri E. Gauthier, M.D.
Seebert J. Goldowsky, M.D.
Arthur E. Hardy, M.D.
Earl J. Mara, M.D.
Arnold Porter, M.D.
Alfred L. Potter, M.D.
S. J. P. Turco, M.D.
John C. Ham, M.D.
Thomas Forsythe, M.D.
Mrs. Mark A. Yessian (Auxiliary)

Science Fair Committee

John Gilman, M.D., *Chairman*
Leland Jones, M.D.
Charles L. York, M.D.

Social Welfare Committee

Peter Mathieu, M.D., *Chairman*
Joseph Dowling, Jr., M.D.
Frank P. Duffy, M.D.
Henry W. Joyce, M.D.
Samuel Nathans, M.D.
Hossein A. Shushtari, M.D.
Leonard Sutton, M.D.
Gustavo A. Motta, M.D.
Earl J. Mara, M.D.
Wilfrid V. Ethier, M.D.

Veterans Affairs Committee

Richard P. Sexton, M.D., *Chairman*
E. Allan Casey, M.D.
John J. Donnelly, M.D.
Joseph C. Kent, M.D.
Phillip Morrison, M.D.
Alton M. Paull, M.D.
John Stuart, M.D.

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLIV JUNE, 1961 NO. 6

RHODE ISLAND POLIOMYELITIS, 1960

Preliminary Report*

JOSEPH OREN, M.D.; RAYMOND F. MCATEER, M.D., AND ROBERT E. SERFLING, PH.D.

The Authors. *Joseph Oren, M.D., of Atlanta, Georgia. Chief, Poliomyelitis Surveillance Unit, Epidemiology Branch, Communicable Disease Center, Atlanta, Georgia.*

Raymond F. McAteer, M.D., Assistant Director of Health (Local Health Services), Rhode Island Department of Health, Providence, Rhode Island.

Robert E. Serfling, Ph.D., of Atlanta, Georgia. Chief, Statistics Section, Epidemiology Branch, Communicable Disease Center, Atlanta, Georgia.

DURING THE SUMMER of 1960, the State of Rhode Island suffered its first poliomyelitis epidemic in five years. This epidemic had an early onset and peak and declined rapidly prior to the epidemic season of past years. Cases tended to be relatively concentrated in several crowded, lower socio-economic areas, especially in several housing projects. Within these areas, the disease seemed to spread rather easily, but transmission to more peripheral areas was quite limited.

The Rhode Island Department of Health recognized in early June that the occurrence of cases was excessive and invited the Communicable Disease Center of the Public Health Service to participate in epidemiological studies. Therefore, a team of investigators was promptly detailed to assist in studying all suspected cases and their environment, as well as the infectious agents and their transmission. This team investigation, which lasted from mid-June until mid-September, has resulted in several findings of interest. The present report deals with preliminary analyses of these data. At this time, it is evident that the pattern of poliomyelitis, as it appeared in Rhode Island in 1960, was quite different from that generally seen in the past.

Methods

During the epidemic investigation, a total of 121 cases of diagnosed or suspected poliomyelitis was carefully studied. One hundred and three of these, including practically all of the paralytic cases, were reported to the state. History and physical and laboratory findings were recorded. A visit was made to each family in which there was a case, in order to study the vaccination status, the home environment, and any possible case contact or source of infection. Laboratory specimens for virologic diagnosis were collected in 90 per cent of the cases. Subsequently, each case received a convalescent evaluation to ascertain the degree of residual paralysis. These follow-up examinations were done sixty days or longer after onset in all but one patient (who moved out of state). At this preliminary stage, on the basis of residual paralysis at sixty days or longer after onset, a strong probable diagnosis of poliomyelitis has been made in seventy-three cases. Thus far, approximately three fourths of these cases have been further confirmed by the isolation of poliovirus type I in the laboratory. In addition, twenty-seven of the cases with no residual paralysis were confirmed as nonparalytic poliomyelitis by poliovirus isolation.

At the end of June and in early September, surveys of the vaccination status of the population of Providence were carried out. The levels of vaccination of various groups were ascertained both early and late in the course of the epidemic in order to evaluate the degree of utilization of vaccine. Other detailed surveys were also done in several housing projects in Providence and Pawtucket in order to measure the protective effectiveness of Salk vaccine. Several other studies were carried out, the results of which will be the topics of subsequent publications. Members of the Kansas City Field Station of the Public Health Service investigated the spread of poliovirus within families and to family contacts. Also, during the epidemic and continuing thereafter, specimens of sewage were collected from a number of sites in Providence and Pawtucket in order to demonstrate the prevalence and spread of enteroviruses in epidemic situations. These specimens were repeatedly collected from a

continued on next page

*From the Communicable Disease Center, U.S. Public Health Service, Department of Health, Education and Welfare, Atlanta, Georgia, and the Communicable Disease Control Division, Rhode Island Department of Health, Providence, Rhode Island.

number of sewer mains draining from relatively homogeneous social and economic sections.

Results: The Epidemiologic Study

The incidence of poliomyelitis in Rhode Island has been quite variable in the past two decades (Table 1). Periodic high-incidence years occurred during the 1940's, followed by a series of epidemic years in the early 1950's. Then, low incidence years, 1956 through 1959, were followed by last summer's epidemic with an attack rate of twelve cases per 100,000. As is usual in temperate climates,[2] the epidemics of earlier years tended to rise during July and August, reach a peak in late August and early September, and decline gradually during the fall. In Figure 1, the weekly incidence curves of polio during the epidemic years of 1953 through 1955 are graphed, and superimposed is the comparable curve for 1960. Since these graphs show cases by week of report, they can only approximate the true occurrence of cases. Nevertheless, it is clear that the 1960 epidemic has a very different pattern, rising rapidly during June and July, reaching an early peak in late July, and then falling off much more rapidly than in previous years.

In the histogram (Figure 2), the epidemic is more accurately described, showing cases by week of onset. Of the 121 cases studied, eighty-six had a preliminary diagnosis of paralytic poliomyelitis and thirty-five were nonparalytic. The precipitous decline in cases after the July peak is seen again for the state as a whole, and it is even more dramatic in the histogram of Providence cases. The epidemic in Pawtucket followed a similar pattern. However, the first cluster of cases in Pawtucket was entirely limited to the Prospect Heights housing project, while the subsequent cases were scattered. Outside of these two metropolitan concentrations, cases were more widely distributed, both temporally and geographically.

The level of Salk vaccination within Rhode Island and within Providence was generally quite high prior to the epidemic. From 1955 through May of 1960, approximately 1,800,000 doses of poliomyelitis vaccine had been shipped into the state. During the epidemic season of 1960, from June through September, an additional 500,000 doses of vaccine were distributed. Approximately 300,000 doses were dispensed via free clinics throughout the state, and another 200,000 doses were dispensed via private practitioners. As indicated in the graph (Figure 3), the greatest proportion of this vaccine was distributed during July, immediately prior to the sudden fall-off in the epidemic. Previous to the large-scale immunization campaign, the vaccine had not been uniformly utilized, and there were pockets of poorly vaccinated groups who remained susceptible to disease. The massive number of immunizations given during the epidemic weeks, which did reach the previously unvaccinated groups, seemingly decreased the number of susceptibles to a point below which the epidemic could no longer spread. In this way, vaccine was probably instrumental in shortening the epidemic.

The distribution of poliomyelitis in Rhode Island in 1960, in contrast to previous years,[3] was not uniform. A large majority of cases, both paralytic and nonparalytic, was localized within the greater metropolitan area, with very few occurring in the less populous and more peripheral areas

TABLE 1
ANNUAL POLIOMYELITIS RATES, RHODE ISLAND

Year	Population*	Reported Cases†	Attack Rate†
1940	719,000	16	2.2
1941	731,000	37	5.1
1942	748,000	6	0.8
1943	760,000	186	24.5
1944	795,000	13	1.6
1945	776,000	9	1.2
1946	770,000	88	11.4
1947	776,000	137	17.7
1948	787,000	8	1.0
1949	801,000	157	19.6
1950	777,000	55	7.1
1951	776,000	15	1.9
1952	796,000	114	14.3
1953	814,000	295	36.2
1954	818,000	123	15.0
1955	827,000	422	51.0
1956	846,000	9	1.1
1957	857,000	0	0
1958	865,000	3	0.3
1959	875,000	10	1.1
1960	859,488	103	12.0

* State populations based on census estimates.
† Case rate per 100,000 population.

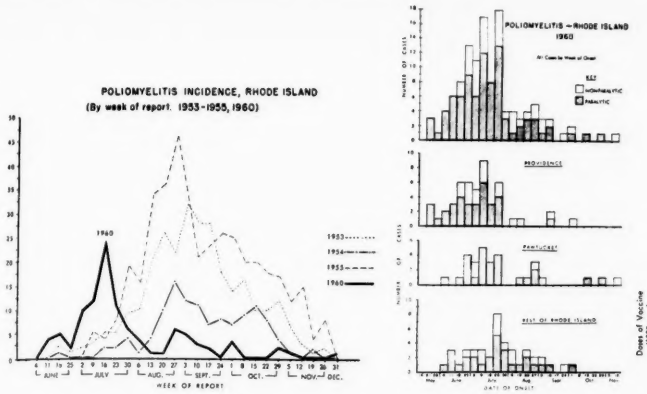


FIGURE 1
Annual Poliomyelitis Incidence, Rhode Island by Week of Report: 1953-1955, 1960

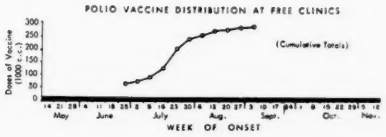


FIGURE 2
Poliomyelitis, 1960, by Week of Onset in Rhode Island, Providence and Pawtucket

FIGURE 3
Polio Vaccine Distribution at Free Clinics in Rhode Island, Cumulative by Weeks, During the Epidemic

FIGURE 4
Geographic Distribution of Poliomyelitis Cases, Rhode Island, 1960

FIGURE 5
Poliomyelitis Distribution in Providence, Rhode Island, 1953, 1955 by Census Tract

FIGURE 6
Poliomyelitis Distribution in Providence, Rhode Island, 1960 by Census Tract (according to preliminary diagnosis)

(Figure 4). Almost two thirds of all cases were located in the Providence and Pawtucket metropolitan concentrations. Relatively few cases occurred in the adjacent areas of Massachusetts. There was, however, some concentration of cases in western Connecticut, in the Groton-New London area early in the summer and in the more rural Windham County area later in the summer.[4]

On the basis of detailed surveys, the census tracts in Providence were classified according to socio-economic level. The lower socio-economic tracts are concentrated largely within the central part of the city and in South Providence. During the years preceding the introduction of Salk vaccine, poliomyelitis epidemics were widely and relatively uniformly distributed throughout the city without preference for any social or economic groups (Figure 5). In comparing the spot map for 1960 with those for 1953 and 1955, it is evident that the distribution is no longer uniform (Figure 6). Rather, the 1960 cases were almost entirely localized within the census tracts with lower and lower-middle socio-economic classification. A concentration of cases occurred in the Chad Brown housing

continued on next page

project in north central Providence, and there was a relative concentration in South Providence. The degree to which the upper economic areas were spared is most remarkable. It is of great importance that the surveys clearly demonstrated that the lower socio-economic areas of the city were less well vaccinated than the upper areas.

In the detailed laboratory and clinical study of the 121 cases with suspected poliomyelitis, one hundred have thus far been confirmed. Another seven cases have been diagnosed as aseptic meningitis due to other than poliovirus etiology, including mumps, ECHO and Coxsackie viruses. Nine cases with the aseptic meningitis syndrome did not have laboratory specimens submitted. Several cases are still under study. The remainder of this discussion will deal with the 100 cases confirmed as poliomyelitis, omitting thereby those due to other than poliovirus etiology.

As in most series, this outbreak involved males more commonly than females.[5] However, in Rhode Island the 1960 incidence was perhaps more disproportionate than usually seen; fifty-nine per cent of the cases were in males and only 41 per cent in females. Among children under ten years of age, fifty cases were in males and only thirty-five in females. All major ethnic groups in the population were involved, with relatively large numbers of cases in children of French, Italian, English, and Irish descent. There were only three cases in Negroes, quite proportionate to the low Negro population of Rhode Island.

There was a relative predominance of cases among young children in the pre-school age group, a more "infantile" type of disease than was seen a decade ago when the majority of cases was in the school age population.[6] The great proportion of cases among young children is emphasized by the fact that 85 per cent of the paralytic cases were in children under ten years of age (Table 2). Although the number of cases confirmed as nonparalytic poliomyelitis is small, it is noteworthy that the age distribution is very similar, with 85 per cent of the cases also under ten years of age. It has generally been assumed that nonparalytic poliomyelitis involves an older age population[7] than the paralytic disease. However, when cases due to other causes of aseptic meningitis are eliminated, it is seen that the true poliomyelitis cases have essentially the same age distribution, whether paralytic or nonparalytic.

Of great importance in Table 2 is the distribution of cases by vaccination status. More than 56 per cent of the paralytic cases had had either no doses or only one dose of vaccine. On the other hand, twenty-six per cent of the cases had had three or more doses. These percentages are quite comparable to the national percentages of cases among vaccinated and unvaccinated.[8] Before assuming that the number of vaccine failures is excessive, it is necessary to consider not only the number of cases in each group, but also the number of persons at risk in each dosage group. Although a greater proportion of the child-age population

TABLE 2
CONFIRMED POLIOMYELITIS – RHODE ISLAND – 1960
AGE DISTRIBUTION BY VACCINATION STATUS

Paralytic with Residual

Age Group	Doses of Vaccine 0	1	2	3	4	5	Total	Per cent
0-4	12	12	7	4	3	...	38	52.1
5-9	5	7	5	5	1	1	24	32.9
10-14	...	...	1	3	1	...	5	6.8
15-19	1	...	...	...	...	...	1	1.4
20-29	2	2	...	1	...	...	5	6.8
30+	...	...	...	...	...	...	...	
Total	20	21	13	13	5	1	73	100.0
Per cent	27.4	28.8	17.8	17.8	6.8	1.4	100.0	

Nonparalytic

Age Group	Doses of Vaccine 0	1	2	3	4	5	Total	Per cent
0-4	4	2	3	1	1	...	11	40.7
5-9	3	2	3	4	...	...	12	44.4
10-14	...	...	...	1	2	...	3	11.1
15-19	...	...	...	...	1	...	1	3.7
20-29	...	...	...	...	...	...	...	...
30+	...	...	...	...	...	...		
Total	7	4	6	6	4	...	27	100.0
Per cent	25.9	14.8	22.2	22.2	14.8	...	100.0	

had been vaccinated than were left unvaccinated, many more cases occurred in the relatively small unvaccinated group. Thus, the attack rate among the vaccinated was much smaller than the rate among the unvaccinated, and the level of effectiveness of vaccine protection is quite high, as will be demonstrated. It must be mentioned also that Table 2 is somewhat misleading in that it includes all doses of vaccine given to these patients prior to the onset of illness. Thus, six of the twenty-one patients with one dose of vaccine in this table received their vaccine less than one week prior to onset. Also, two of the cases with two doses of vaccine had received their second dose within three days prior to onset. Thus, in these eight cases, the vaccine had been received too recently to have produced significant antibody protection against infection already present.

When all cases were evaluated several months after onset the outcome was generally quite good. Thus, sixty-five of the 100 confirmed cases had no significant residual paralysis. The degree of residual paralysis did not bear any consistent relationship to the previous vaccination status. Fully 37 per cent of the confirmed cases had some degree of bulbar involvement, including twenty-four with bulbo-spinal disease. The more severe results in cases with cranial nerve involvement were entirely limited to those with bulbo-spinal paralysis, and included all six fatal cases. Thirteen cases had bulbar involvement alone, and all had minor or no residual. An unusually large number, twenty-one cases, had facial weakness, including five with isolated facial palsies. It has been suggested that pure facial paralysis is rarely due to poliomyelitis, but in three of these five cases poliovirus has been recovered. Interestingly, three of 17 confirmed cases, originally diagnosed as nonparalytic, had minor residual paralysis. Obviously, paralysis either may not be noted initially or may develop insidiously during the period after preliminary diagnosis is made. This emphasizes the importance of convalescent evaluations in assessing the true morbidity in all cases of poliomyelitis.

The Statistical Study

In the city of Providence, various surveys were made during the course of the epidemic to measure vaccine status and socio-economic levels of subpopulations of the city and of areas selected for sewage sampling.*

The present report provides a summary of findings of a survey conducted in early September, toward the close of the epidemic and the intensive vaccination program. At this time, 1960 census data by enumeration district were available; and, with use of these data, a probability sample of approximately one dwelling unit in 70 in the city of Providence was selected for interview. Information was collected on vaccine status of each household member as of the first of June, July, August, and September. Information was also obtained on the socio-economic status of each household using the two-factor index of social position developed by Doctor A. B. Hollingshead of Yale University.[9] An average value of the index was completed for each census tract by weighting the index for each sample family by the number of family members. The census tracts were then ranked and divided into four quartiles classified as upper, upper-middle, lower-middle, and lower socio-economic levels.

The survey results indicated that a total of 137,534 doses of vaccine were administered to the 206,532 persons in the population. On the average, each person under 20 years of age received approximately one dose. In the age group 20-40 years, an average of approximately three doses was received by each four persons; and, for those over 40, the average was approximately two doses for each five persons.

It was found at the close of the epidemic (considering previous as well as recent vaccination) that very few children had not received at least one dose of vaccine. In the age group 5-14 the percentage with one or more doses was nearly 100 per cent of the population in each socio-economic area. Under five years of age, the percentage with one or more doses was over 90 per cent in each socio-economic area.

When the percentage with four or more doses was examined by age and socio-economic level, a less favorable result was found. Among children under five years, the percentage with four or more doses ranged from approximately 30 to 60 per cent by socio-economic group. Among children 5-14 years, corresponding percentages ranged from 60 to 80 per cent. In the age-group 15-39, the percentage with four or more doses ranged from approximately 40 per cent to 70 per cent. Thus, although in terms of persons receiving at least one dose the population was well-covered at the end of the epidemic, there remained need for considerable effort to complete the immunization series for many persons who received their first (or first and second) inoculations during the epidemic period.

The survey data also enabled calculation of vaccine effectiveness estimates. For this purpose, the population was classified by vaccination status according to age and socio-economic level as of June 1 and July 1. Attack rates in the unvaccinated were then calculated for the periods May 16

concluded on next page

*These surveys were carried out under the directions of Doctor Dana Quade, Epidemic Intelligence Officer, Communicable Disease Center, with support and assistance of the Rhode Island State Health Department and the City of Providence Health Department.

through June 15 and June 16 through July 21. From these rates an expected number of cases in the vaccinated (three or more doses) were calculated for each sub-population in each time period. The total number of expected cases in the vaccinated was 31, with six cases observed. Effectiveness was thus calculated as follows:

$$\frac{31-6}{31} \times 100 = 81 \text{ per cent.}$$

This result is similar to effectiveness estimates made in the 1959 poliomyelitis epidemics in Des Moines and Kansas City.[10,11,12]

Summary and Conclusions

The poliomyelitis epidemic of 1960 in Rhode Island followed a different pattern than epidemics in past years. The distribution of cases, both geographically and temporally, was atypical. After a rapid early season rise, the epidemic declined dramatically. Furthermore, cases were remarkably concentrated within lower socio-economic census tracts and housing projects within the metropolitan Providence area. It is felt that these epidemiologic characteristics were determined, at least in part, by the massive vaccination program within Rhode Island preceding and during the epidemic.

There was a predominance of cases among poorly immunized young children, with 85 per cent of both paralytic and nonparalytic cases under 10 years of age. Three fourths of the paralytic cases had had no vaccine or inadequate vaccination. However, the degree of residual paralysis bore no relationship to the previous vaccination status of the patients. The better vaccinated areas of Providence were consistently spared.

Clinically, two thirds of the cases had no significant residual paralysis. There was a high incidence of bulbar, and especially facial, involvement. Poliovirus type I was isolated from a great majority of cases, including several with isolated facial paralysis.

Surveys of vaccination status in Providence indicated a very wide distribution of Salk vaccine. However, considerable effort still is needed to fully immunize the susceptible population.

The effectiveness of Salk vaccine in the 1960 epidemic, for three or more doses, was 81 per cent.

BIBLIOGRAPHY

[1] Reported Incidence of Selected Notifiable Diseases: Vital Statistics Special Reports 37(9):207-209, June 15, 1953

[2] Thrupp, L. D.; Forester, H. E., and Brody, J. Q.: Poliomyelitis in the United States, 1957. Public Health Rep. 74:535, 1959

[3] Lehman, S. F.: The 1953 Outbreak of Poliomyelitis in Rhode Island. Rhode Island Med. J. 37:259, 1954

[4] Rindge, M. E.: Poliomyelitis in Connecticut, 1960. Conn. Health Bull. 75(4):111, 1961

[5] Nathanson, N.; Thrupp, L. D.; Hall, W. J.; Langmuir, A. D.; Cornell, R. G.; Forester, H. E.; Church, R. E.; Hall, J. B.; Hilderbrand, M.; Shaughnessy, M. I.; Morrissey, R.: Epidemic Poliomyelitis During 1956 in Chicago and Cook County, Illinois. Amer. J. Hyg. 70:107, 1959

[6] Dauer, C. C.: The Changing Age Distribution of Paralytic Poliomyelitis. Ann. N. Y. Acad. Sci. 61:943, 1955

[7] Hall, W. J.; Nathanson, N., and Langmuir, A. D.: The Age Distribution of Poliomyelitis in the United States in 1955. Amer. J. Hyg. 66:214, 1957

[8] Public Health Service, U. S. Department of Health, Education, and Welfare: Morbidity and Mortality Weekly Report 10(15):2, Apr. 21, 1961

[9] Hollingshead, A. B.: Two Factor Index of Social Position. A. B. Hollingshead, New Haven, Conn., 1957

[10] Speers, J. F.; Chin, T. D. Y.; Marine, W. M.; Hall, E. C.; Gravelle, C. R.: Epidemic Poliomyelitis, Des Moines, Iowa, 1959. J.A.M.A. 174:864, 1960

[11] Marine, W. M.; Chin, T. D. Y.; Gravelle, C. R.; Soergel, M. E.: Effectiveness of Salk Vaccine in Reducing Nonparalytic Poliomyelitis in a Large Urban Epidemic. New Eng. J. Med. 264:903, 1961

[12] Serfling, R. E., and Langmuir, A. D.: Simple Mathematical Model of Bias Arising from Effectiveness Rates Calculated from Heterogeneous Populations with Some Error in Diagnosis, read before the joint meeting of the Biometric Society (ENAR) and the Institute of Mathematical Statistics, Columbia University, New York City, April 21, 1960

DID YOU KNOW?

- That as of the end of 1960, an estimated 132 million Americans had hospital insurance, compared to 77 million at the end of 1950.
- That from 1950 to 1960 the growth in surgical insurance coverage was from 54 million persons to an estimated 120 million persons.
- That in the 10-year period there was an increase from 22 million to an estimated 86 million in the number of persons with regular medical insurance which helps pay for doctor calls and other non-surgical care by physicians.
- That some 25 million persons now have major medical coverage compared to about 100,000 in 1950.
- That the number of persons with loss of income insurance increased from 38 million in 1950 to 43 million.

MACHINE SALES DATE 2,200 YEARS

The sale of accident insurance policies in vending machines is the latest development in a history of automatic merchandising which started about 200 B.C.

The first vending machine dispensed holy water in a Greek temple. In the early 1800's, bulk tobacco was automatically merchandised in English pubs.

Vending machines dispensing penny gum and chocolate bars in packages, and salted peanuts and ball gum in bulk, first appeared in the United States in the late 1880's.

VITAMIN C DEFICIENCY MASQUERADING AS "ARTHRITIS"

MICHAEL G. PIERIK, M.D.

The Author. *Michael G. Pierik, M.D., Visiting Physician, Medical Arthritis Clinic, St. Joseph's Hospital, Providence, Rhode Island.*

A SIGNIFICANT NUMBER of patients referred for evaluation of "arthritis" will ultimately prove to have musculoskeletal or neuritic symptoms due to unrelated disease. That pulmonary neoplasm or lupus erythematosus may produce peripheral arthropathy is well recognized. The association of thyrotoxicosis and subdeltoid bursitis is another example. Hence, a basic proficiency in diagnostic internal medicine would seem to be a prime requisite in the practice of rheumatology. The following case illustrates another disease still occasionally seen in which a correct diagnosis led to a gratifying cure and rehabilitation.

Case Report

W. M., a sixty-nine-year-old white female, was first seen in St. Joseph's Hospital in December, 1957, with characteristic findings of acute thrombophlebitis of the right lower leg. Conservative management consisting of elevation, moist heat, and anticoagulants was successful. The patient was then referred for evaluation of arthritic complaints. The history was of bizarre generalized musculoskeletal aching, with extreme tenderness in the muscles of the arms, legs, and low back for some four years. Actual swelling, increased heat, redness, or limitation of any joint was denied. For the past year, extreme subjective weakness had led to a bed and chair existence. Profound anorexia and mental depression accompanied this. Physical examination, X rays of affected bones and joints, and laboratory studies were normal except for a hypochromic anemia of 10.5 grams of hemoglobin. The patient's symptoms were thought to be functional, secondary to long standing mental depression. With supportive psychotherapy and graduated physiotherapy, the appetite returned to normal. In six weeks all symptoms of pain were gone and the patient walked normally at the time of discharge.

The second admission in December of 1960 was occasioned by a fall with ensuing severe pleuritic chest pain and tenderness. There was a history of gradual development of anorexia and mental depression, similar to that of the first admission. The patient had been forced to return to a wheel chair for the past year. A careful dietary history indicated a nearly complete avoidance of meat, vegetables, and fruit, canned or fresh, for at least eighteen months. Intake had been limited to tea, toast, cereals, and custard. Alcoholism, prolonged medication, or exposure to toxic chemicals were denied by the patient and close relatives. Purpura on the lower extremities and forearm had developed spontaneously in the past twelve months. As on the previous admission, peripheral muscular tenderness was prominent.

Physical Examination: The patient was sallow, edentulous, emaciated, mentally depressed, but well oriented. She complained of extreme left lateral pleuritic chest pain. An enormous ecchymosis extended from the left axilla to the pelvic brim. Purpura ranging in size from a quarter to a half dollar were noted on the extensor surfaces of forearms and lower legs. Folliculitis was not present. Light pressure along the lower tibiae was exquisitely painful. All neurological modalities, both sensory and motor, were intact, except for profound muscular weakness of the legs. There were no signs of rheumatoid or other arthropathy. The remainder of the examination was normal.

X rays revealed multiple recent left lower rib fractures. Views of the long bones were normal. The tourniquet test was normal. Aside from a hypochromic anemia of 11 grams of hemoglobin, all laboratory studies, including coagulation tests were normal. The patient was afebrile throughout her stay.

Because of the unexplained purpura, long bone tenderness and nutritional history, Vitamin C metabolic tests were done while maintaining the patient on an ascorbic acid poor diet:

Fasting Plasma
Vitamin C Level ..... 112 micrograms %
Buffy Coat Vitamin C Level ..... 8 milligrams %
(Method using dinitrophenyl hydrazine was followed)

The following hourly plasma levels were obtained after a single oral dose of 800 mgm. of ascorbic acid:

concluded on next page

First Hour	112 micrograms %
Second Hour	157 micrograms %
Third Hour	180 micrograms %
Fourth Hour	146 micrograms %

Because of the severity of the symptoms due to the fractures, it was not deemed advisable to delay healing to undertake a tyrosine loading determination. Oral ascorbic acid, 50 mgs. daily, was started, in addition to a full diet. At the end of ten days, there was complete clearing of mental depression, muscle weakness, periosteal tenderness, and purpura, in that order. Gait was normal at discharge on the 19th hospital day. Fasting plasma ascorbic acid level, just prior to discharge, was 2.24 mgm.%. The fractures healed uneventfully and the patient has remained well to date.

Comment

Florid or "full blown" scurvy[1] is characterized by hemorrhagic phenomena, particularly in the gingivae, periosteum, and mucous membranes. Hematuria, anemia, and delirium in late stages are seen. The disease should be considered in any case of unexplained bleeding. In subclinical or less advanced cases, insidious weight loss, progressive weakness, objective bone tenderness, and diffuse subjective aching in arms and legs, are suggestive clues. Recognition at this stage is important to proper wound and fracture healing. A low serum ascorbic acid level without clinical signs or symptoms, of course, is not diagnostic. Loading tests are useful in doubtful cases, and finally the response to specific therapy may be the best guide. The disease is more striking in children; women seem more resistant than men. Gingivitis is not present in edentulous patients. Of some interest is the negative capillary fragility test in this case. However, negative tests have been found for as long as six months in experimental diets totally deficient in vitamin C.

SUMMARY

A cure of "arthritis" was possible by a belated recognition of an early symptomatic stage of Vitamin C deficiency. A negative capillary fragility test and absence of gingivitis were noteworthy features.

REFERENCE

[1]Crandon, J. H.; Lund, C. C., and Dill, D. B.: Experimental Human Scurvy, New England J. Med. 223:353, Sept. 5, 1940

May 8 and 9, 1962

151st ANNUAL MEETING

AINHUM

HARRY S. GOLDSMITH, M.D., AND ORLAND F. SMITH, M.D.

The Authors. *Harry S. Goldsmith, M.D., of Boston, Mass. Chief Resident, Third (Boston University) Surgical Service, Boston City Hospital.*
Orland F. Smith, M.D., of Providence, Rhode Island. Chief of Surgery, Pawtucket Memorial Hospital, Pawtucket, Rhode Island.

IN THE NEW ENGLAND AREA a tropical disease can be easily misdiagnosed simply because one is unaware of its existence; an example of this is ainhum. Ainhum (dactylolysis spontanea) is a disease peculiar to Negroes, characterized by development of a fibrotic band of the toes usually forming at the base of the fifth toe. This condition mainly affects Negro males of the tropics and subtropics and it is only rarely seen in the temperate regions of the world. Clark[1] in 1860 was the first to report this condition in the African Gold Coast Negroes as being one of dry gangrene of the little toe. daSilva Lima[2] in 1867 first introduced the African word ainhum, which means "to saw," to classify this disease. In 1881 Hornaday[3] reported the first case from this country, and since that time approximately 100 reported cases have been added to the world literature from the United States.

Various etiological entities have been reported as being the underlying cause for this disease: leprosy, syphilis, infection and trophoneurosis, just to mention a few. However, none of these conditions is consistently present, nor can they explain the reason ainhum most frequently attacks the small toe of the Negro male. This multiplicity of unproven etiological causes is therefore an indication that the basic pathology for this condition is as yet unknown.

The disease is characterized by a transverse furrow which usually develops in the region of the digito-plantar fold of the fifth toe. A small papule may appear in the region of this fold which on occasion becomes secondarily infected. This may become painful and for the first time attract the attention of the patient to the change that is taking place. With the passage of time the transverse band begins to extend laterally until it eventually encircles the entire toe. The fibrotic constriction then in effect becomes a ligature which, with increased constriction, slowly cuts off the distal blood supply. Eventually absorption of bone takes place beneath the constricted area; and in the end stages dry gangrene results, with autoamputation occurring distal to the fibrotic band.

Grossly one finds the toe distal to the fibrosis to be bulbous, edematous, and on occasion discolored from gangrene. The tissue changes directly beneath the constricting band as well as any degree of bone absorption is dependent upon the duration and extent of the fibrosis. This fibrotic process results in minimal to complete occlusion of the underlying blood vessels resulting in the trophic changes that occur.

In untreated cases, autoamputation is usually the end result. Likewise, the only effective therapy for this condition in the light of our present knowledge is amputation of the involved toe. Brown[4] in 1959 reported a case of bilateral ainhum which he treated by multiple Z-plasties with favorable results. Nevertheless, one wonders whether plastic procedures are justified in a condition that is solved so easily by amputation of a toe that is already partially destroyed. The loss of a fifth toe on either foot is in no way a handicap.

Case History

G.H. is a seventy-two-year-old Negro female housewife who entered the hospital complaining of "cracking and swelling" of the fifth toe of her right foot. Her entire life had been spent in the New England area. Approximately one year prior to admission, she began to notice cracking of the plantar surface of her fifth right toe which over a period of time became quite painful. She was seen by her family physician who felt her condition was one of "athlete's foot" and treated her with epsom salt soaks of both feet. This treatment was carried out for a period of one month, at the end of which time "pus" escaped from the involved area and the pain disappeared. She then remained asymptomatic until three months prior to admission at which time she again noticed a painful furrow forming in the previously affected area of her fifth right toe. This furrow began to extend laterally until the entire toe was encircled, eventually leading to swelling and gangrene of the portion of the

concluded on next page

From the Department of Surgery, Pawtucket (Rhode Island) Memorial Hospital.

toe distal to a fibrotic band. It was at this time that she came to the hospital for definitive treatment.

On physical examination the patient was a well-nourished Negro female complaining of pain in her right fifth toe. This toe was bulbous and black distal to the characteristic constricting band (Fig. 1). Palpation of this toe caused marked discomfort. The dorsalis pedis and posterior tibial pulses were present bilaterally. The remainder of the physical examination was remarkable only for bilateral cataracts, Grade 2 arteriosclerotic retinopathy, and external hemorrhoids. Roentgenograms of the involved area showed bone atrophy of the distal portion of the proximal phalanx of the right fifth toe (Fig. 2). The results of the blood and urine studies were within normal limits. The serum test for syphilis was negative. The patient subsequently underwent amputation of the right fifth toe which was performed under a spinal anesthesia. The postoperative course was uneventful with the wound healing by primary intention.

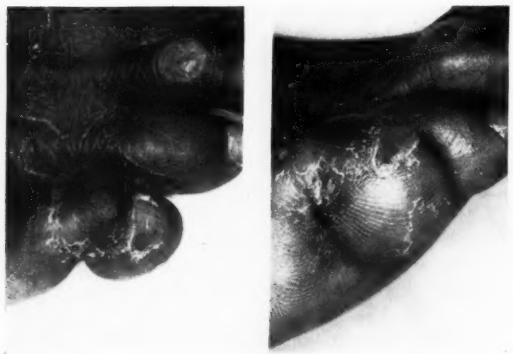


FIGURE 1

Photographs taken at time of amputation of the fifth toe. Constricting band can be seen at proximal end of involved toe.

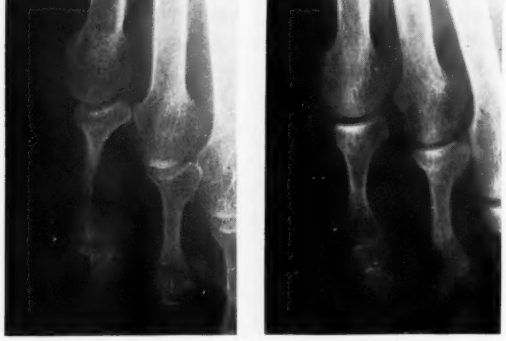


FIGURE 2

Comparison roentgenograms showing constriction of proximal portion of right fifth toe with underlying bone destruction.

SUMMARY

Ainhum is a disease seen mainly in Negroes from tropical and subtropical areas of the world, appearing only rarely in patients from the temperate climates. Many theories have been proposed regarding the etiology of this condition but none of them has been proven. The disease usually constricts the fifth toe at the base with eventual bone atrophy and gangrene. The treatment of this condition is amputation.

REFERENCES

[1]Clark, R.: Remarks on the Topography and Diseases of the Gold Coast, West Coast of Africa. Tr. Epidemiol. Soc. London 1:76, 1863

[2]daSilva Lima, J. F.: On Ainhum. Arch. Dermat. 6:367, 1880

[3]Hornaday, E. H.: Ainhum. Tr. M. Soc. North Carolina. 28:76, 1881

[4]Brown, E. C.: Bilateral Ainhum Treated by Multiple z-Plasties. Plast. & Reconstruct. Surg. 23:550, 1959

[5]Bergner, L. H.; Winfield, J. M.: Ainhum (Dactylolysis Spontanea) Review of the Literature and Report of a Case. Am. J. Surg. 100:480, 1960

[6]McKenna, C. M.; Hermann, R. E.: Ainhum — Occurrence of a Case in Northern Ohio. J.A.M.A. 173:1015, 1960

[7]Chancey, R. L.; Gipson, B. F.: Ainhum. U.S. Armed Forces M. J. 7:101, 1956

[8]Riley, L. H.; Cantrell, J. R.: Clinical & Pathological Observations in Three Cases of Ainhum. Arch Surg. 79:165, 1959

May 8 and 9, 1962

151st ANNUAL MEETING

May 8 and 9, 1962

SESQUICENTENNIAL

MEETING

(151st Session)

Rhode Island Medical Society

Progress Notes...

NEWER ADVANCES AND PRESENT-DAY PROBLEMS IN GASTROINTESTINAL SURGERY*

RICHARD T. SHACKELFORD, M.D.

The Author. *Richard T. Shackelford, M.D., of Baltimore, Maryland. Assistant Professor of Surgery, Johns Hopkins University School of Medicine, and Johns Hopkins Hospital.*

I SHALL PRESENT my personal evaluation of those *Newer Advances and Present-Day Problems in Gastrointestinal Surgery* with which I have had some personal experience. Advances have been made, as can be seen from Table 1, of the approximate operative mortality rates at my institution in 1930, when I was a house officer, and again in 1960.

TABLE 1

Operative Mortality Rate	1930	1960
Peptic Ulcer Operations	10%	1%
Gastric Malignancy Resections	25%	5%
Gallbladder Operations	10%	0.5%
Resection of Colon and/or Rectum	30%	1%

I credit these to the following developments.

The presence of scientific anesthetists, better anesthetics and apparatus, and endotracheal intubation need no comment.

Nasogastric intubation has been particularly helpful in minimizing anastomotic leaks in gastric resections and in practically eliminating postoperative paralytic ileus which was particularly common and fatal after operations on the gallbladder.

More accurate fluid, electrolyte, and blood replacement has also been a big factor and will be commented on again in a moment. The use of antibiotics and bowel preparation has been to a considerable degree responsible for the general decrease in mortality on operations of the colon and rectum.

A still existing serious problem that has not been satisfactorily solved is the estimation of blood volume before and after operation because patients may die either from too little or too much fluid and blood replacement. At present we have found the radioactive chromate 51 method of determining blood volume to be the most useful. It is run by the house officers, obtains blood volume determinations in about ten minutes, and is repeatable in about four hours. I have had several cases in which I am certain that these determinations prevented our giving too much or too little fluid to a critically ill patient in whom the mistake would have been fatal.

Esophagus

The treatment of carcinoma of the middle and upper thirds of the esophagus is still an unsolved problem. The operative attack is one of great magnitude. In my hands it has not been satisfactory.

I resected sixteen cases with no five-year survivals. The next forty cases were treated by rotation X-ray therapy and again there were no five-year survivals. However, more patients survived for a longer time than with surgery and all were able to swallow until their demise. This seemed to me to be better palliation than I was able to give by surgery, and in addition it spared them both the expensive hospitalization and suffering that surgery produced. We are now treating these patients with cobalt radiation. This has started too recently for me to have any statistics. I do not mean that surgery should be abandoned by all people in treating this disease. Sweet in Boston and Parker in Charleston as well as others have produced some five-year cures. They are concentrating on this field and may eventually produce a satisfactory procedure that all of us can use. In the hands of the ordinary general surgeon the results are not good.

continued on next page

*Presented before the House Officers' Association at Rhode Island Hospital, Providence, Rhode Island, May 5, 1961.

TABLE 2
Carcinoma of Middle and Upper Thirds of Esophagus

Treatment	Total Cases	Survival				
		Average	5 yrs.	2 yrs.	1 yr.	6-12 mos.
Surgical	16	9 mos.	0	0	1	6
Rotational X-ray	40	7.9 mos.	0	4	5	14

On the other hand carcinoma of the lower third of the esophagus has a much more favorable outlook when attacked by surgery. This is shown in Table 3 of my results in an admittedly small series:

TABLE 3
Carcinoma of Lower Third of Esophagus

Total Number of Cases	**6**
Operative Mortality	0
Died with Metastases but palliated 11 months, 4 yrs.	3
Living and well for 4 yrs.	2
Living and well for 5 yrs.	1

I think that these patients should be treated by surgery.

Stomach

Carcinomas of the stomach are still a serious problem. In our opinion a subtotal gastrectomy is the treatment of choice, but a total gastrectomy is used when a safe margin above the tumor cannot otherwise be obtained. The five-year survival for curative resections runs between forty and fifty per cent, but the discouraging fact is that the over-all five-year survival is only five to ten per cent because such a large percentage of these patients come in with a tumor that is nonresectable or amenable only to a palliative resection. I might add that we believe in palliative resection for a resectable tumor even in the presence of metastases, unless they are so extensive that the life expectancy is short. Removal of the primary tumor prevents its future bleeding or obstruction and makes the patient much more comfortable for his remaining days.

The results in the treatment of sarcoma of the stomach are considerably better than those of carcinoma. We[1] recently reviewed our primary sarcomas of the stomach. They consisted of three types: reticulum cell (large pleomorphic cell) sarcomas, lymphosarcomas (small round cell), and leiomyosarcomas (spindle cell).

Reticulum cell sarcomas commonly develop lymphatic metastases, though not as commonly as carcinomas. These tumors were moderately sensitive to radiation therapy. The most successful form of treatment was resection plus postoperative radiation. Those that were nonresectable responded to a variable degree to radiation and/or nitrogen mustard therapy. Their over-all five-year survival was 40 per cent. Some of the cases that had been resected died of other causes in later years and autopsy showed no evidence of recurrence. All cases treated without surgery died eventually of their disease.

Lymphosarcomas of the stomach were usually associated with involved glands and other structures. They were very sensitive to radiation therapy. The best results followed treatment by resection plus postoperative radiation. Those which were nonresectable responded to radiation and chemotherapy. Their over-all five-year survival was 50 per cent but none was entirely free of their disease nor died without autopsy evidence of disease after any form of treatment.

The leiomyosarcomas of the stomach are the most favorable group of all. They rarely metastasize to the lymph glands; in fact this occurred in only one of the thirteen that we studied. They are completely resistant to radiation and chemotherapy. The best results followed resection of the stomach and its tumor. There is no means of palliating those that cannot be resected. The five-year over-all survival in these tumors was 50 per cent and the five-year survival of those that were resectable was 60 per cent. Furthermore, those that survived for five years were clinically free of the disease and any that died from other causes were shown to have no evidence of recurrence at autopsy. Although it was stated that the prognosis of these tumors is good it depends almost entirely on whether there has or has not been vascular invasion.

Doctor Sumner Wood went over all of our specimens without knowing the clinical outcome of the patients. He found vascular invasion by the tumor in seven cases. Of these seven, six have died of the tumor, and one is still living, four months postoperatively.

On the other hand he could find no vascular invasion in five cases. None of those had died from their tumor; one died a postoperative death; two are living and well for ten and seven years; and two others died from other causes six and three years after their operation, autopsy showing no evidence of recurrence of the tumor. The thirteenth case had too little tumor tissue in the secondarily resected specimen for vascular invasion to be evaluated.

A real lesson can be learned from the thirteenth case. The patient, a female, was first operated upon in another city for upper gastrointestinal bleeding, and a small tumor in her stomach was found. A frozen section was made and interpreted as a benign leiomyoma. Accordingly, it was locally excised with what appeared to be an adequate margin. Later permanent sections showed that it was a leiomyosarcoma. She was transferred to the Johns Hopkins Hospital where a secondary subtotal gastrectomy was decided upon despite the fact that by X-ray and even at operation there was no visible or palpable evidence of persistence of the tumor. The pathologic section showed residual tumor cells at the site of her healed former gastrotomy wound. She was nineteen years' old then, and is now twenty-eight. The moral to this is that even a benign appearing leiomyoma should be widely excised, because one cannot tell whether it is benign

or malignant from the frozen section.

Duodenum

The elective surgical treatment of duodenal ulcer is still an unsettled problem. The argument concerns whether to do a subtotal gastrectomy, or a vagotomy plus a 50 per cent gastrectomy or some shunting operation. The treatment of duodenal ulcer has gone through many fads and cycles and now is about back to where it was thirty years ago. Personally I prefer a subtotal gastrectomy, because it has given me satisfactory results over the years. As the late Knute Rockne used to say, "When your running attack is working why forward pass?" On the other hand vagotomy with a conservative gastrectomy or a shunt operation is gaining popularity at the present time. It does have a lower mortality and seems to give equally satisfactory results. It is possible I may change to it later though I have not so far. The degree of preoperative acidity influences the choice. Of course the primary treatment of a duodenal ulcer is medical. Surgery is reserved for the complications of bleeding, perforation, obstruction, or intractability.

The treatment of a perforated peptic ulcer is also still controversial. I prefer simple suture, with biopsy of any ulcer that is on the gastric side of the pylorus. In our hands this has provided a 1 per cent mortality. A twenty-year follow-up of a series of these patients showed that during the following twenty years 33 per cent had no further trouble, another 33 per cent required medical treatment, and the remaining 33 per cent required reoperation for a peptic ulcer. We reserve immediate resection of a perforated peptic ulcer for young, good risk patients with recent perforation, minimal inflammation about the ulcer, and viscera mobile enough to be easily resected. I firmly believe that one should perform the simplest and safest operation that will take care of the present emergency.

Gastrointestinal Bleeding

Another unsettled problem is the treatment of emergency gastrointestinal bleeding from an unknown source. It is important, when possible, to try to diagnose the source before any operation is performed. The history provides some clue. If there has been hematemesis, suspect a bleeding point proximal to the ligament of Treitz. Perform an emergency barium swallow X-ray study, and/or esophagoscopy if esophageal varices are considered a possibility. If there has been vomiting without hematemesis, then suspect a lesion distal to the pylorus. Again we do a barium swallow X-ray study, a proctoscopic examination, and a barium enema examination. When there has been no vomiting, one must consider a location anywhere in the gastrointestinal tract, but more likely in the lower bowel. For this we do a proctoscopic examination first, then a barium enema, and finally the other studies mentioned above if necessary.

When the site of bleeding is still unknown and emergency operation is necessary, the following routine has been helpful. We look first for the highest level of bluish discoloration of the bowel and then palpate and inspect the gastrointestinal tract at and above that level. We then look at the liver for evidence of cirrhosis and at the omental veins for evidence of distention from portal hypertension. Next the stomach is opened by a long gastrotomy which extends from the cardia through the pylorus if necessary. We then look at the jejunum for diverticula, both false and true, and, if none is seen, isolate the jejunal loop between compression clamps and insufflate it to distend any diverticula that are present to make them more prominent. If there has been no hematemesis, the colon is opened by a colotomy and its interior inspected with a sterile proctoscope as it is distended with air to flatten out the mucosal folds. A blind gastrectomy is not done unless blood was found in the stomach with no specific bleeding area and is not coming up from the pylorus or down from the cardia. One must remember that 25 per cent of upper gastrointestinal bleeders are bleeding from something else than a peptic ulcer.

The treatment of esophageal varices is still a problem. When bleeding is active we insert a Sengstaken tube. If this does not control the bleeding or if the bleeding recurs after the tube is released, I have ligated the varices through a thoracic approach with temporary success. Others have successfully stopped the bleeding by the Tanner operation which consists of transecting the upper end of the stomach. These are not definitive operations. The best procedure apparently for relieving the portal hypertension, which is the cause of varices, is some form of a portacaval shunt. This operation should not be undertaken lightly. Although McDermott[2] has recently reported a brilliant series at the Massachusetts General Hospital with a mortality around 10 per cent, one must remember that he and his associates have had an unusually large experience with the condition. I am quite certain that the mortality will be around 20 per cent when performed by ordinary surgeons who do not specialize in this operation. Furthermore the cases must be carefully selected. Some people advocate an emergency portacaval shunt during the active bleeding. I have not attempted this, so I cannot discuss it.

On the other hand a portacaval shunt that is performed electively can be very beneficial in properly selected cases. There is difference of opinion about the type of shunt to be performed. The choice often will be dictated by the anatomical conditions

continued on next page

encountered. The most desirable shunt is one between the portal vein and the vena cava. This may be performed as an end-to-side, side-to-side, or double end-to-side. The reason for the side-to-side and the double end-to-side procedure is that it has now been demonstrated that there is a considerable retrograde flow of venous blood from the liver in the portal vein, at least in some cases. However, a side-to-side anastomosis is more difficult to perform than an end-to-side; so the double end-to-side anastomosis has virtue.

The portal vein may be found to be thrombosed and unsuitable for an anastomosis. In such a case an anastomosis can be made between the splenic vein and the left renal vein. This anastomosis does not shunt as much blood as the portal caval anastomosis; and McDermott[2] showed very nicely that there is a greater incidence of recurrence of bleeding after this type of shunt than after the portacaval shunt. We perform portacaval shunts only for patients with esophageal varices that have bled. Some individuals are advocating that it be performed prophylactically before the patient bleeds at all. This is a much debated issue that has not yet been resolved. One must also remember that some patients with esophageal varices never bleed, while some others bleed once or twice and never have a recurrence of the bleeding. They are very much in the minority.

Jejunal false diverticula occur on either side of the mesentery of the jejunum. It has not been generally recognized that they are a potential source of upper gastrointestinal tract bleeding. Hemorrhage from them may consist of simple melena or massive hemorrhage. Clinically they mimic a bleeding duodenal ulcer. They may be seen in a gastrointestinal X-ray series. We[3] reported three of these cases and collected twenty-one others from the literature, in all of which the diverticula were the cause of hemorrhage. The symptoms are listed in Table 4.

TABLE 4
Symptoms of 24 Patients with Bleeding Jejunal Diverticula

Asymptomatic Chronic Melena	5
Asymptomatic Massive Melena	4
Chronic dyspepsia, hematemesis and Melena	3
Pain, Vomiting and Chronic Melena	3
Pain, Vomiting and Massive Melena	3
Asymptomatic Vomiting and Massive Melena	3
Asymptomattic Hematemesis and Massive Melena	1
Asymptomatic Hematemesis	1

The following short case report demonstrates the resemblance to bleeding from a peptic ulcer:

A fifty-eight-year-old white male entered the Perry Point Veterans Hospital in June, 1959. He had been asymptomatic until the sudden onset of syncope, vomiting without hematemesis, and massive melena the previous night. The amount of hemoglobin was only 6 gm. after the transfusion of 2500 ml. of blood. Laparotomy (R.T.S.) was performed and 59 cm. of jejunum containing multiple diverticula were resected. One diverticulum could be seen at operation to be refilling with blood when emptied. No ulceration could be found in the specimen. Recovery has been complete.

An important point about these cases is that at operation you may not easily see the diverticula or, if diverticula are there, their presence does not necessarily mean that the bleeding is coming from them. It is helpful to distend the jejunum with air to visualize them better. If you pinch the diverticula you may start up active bleeding and demonstrate its accumulation in the offending diverticulum.

It is important for pathologists to realize that these are potential sources of gastrointestinal hemorrhage. In any patient who has died from gastrointestinal bleeding without a site of the bleeding having been found at autopsy this segment of the bowel should be blown up with air, otherwise the diverticula may be missed.

Hiatus Hernia

There is still a difference of opinion as to what should be done for hiatus hernias. I agree that hiatus hernias that are asymptomatic need not be operated upon. However those that do have symptoms should be operated upon because in our experience they can develop the complications listed in Table 5.

TABLE 5
Complications of Hiatus Hernia

Non-X-ray — visible esophagitis with bleeding and anemia, all four corrected by hernia repair	4 cases
Esophagitis Stenosis:	3 cases
1 corrected by esophagogastrectomy - Stenosis recurred.	
2 corrected by esophageal resection and jejunal interposition — too recent for evaluation.	
Strangulation with perforation, both fatal.	2 cases

One of the complications is the development of esophagitis that is too mild to be visualized by an X-ray study, but yet is sufficient to cause bleeding or anemia. This is one of the causes to be looked for when one has a patient with melena and anemia of unknown cause. I have had four of these patients, one in my immediate family, all of whom were cured of their bleeding and anemia by repair of the hernia. They have all remained well.

Another serious complication is the development of a severe stenosis due to esophagitis. These cases are much easier to prevent than they are to cure. Operations for correcting esophageal stenosis are not completely satisfactory. I have had three of these patients. In one the stenosis was corrected by esophagogastrectomy, but stricture at the anasto-

TABLE 6

Total Routine and Diagnostic Proctoscopies	546 patients
Positive findings requiring biopsy in 40 patients (7.3%)	
Routine Proctoscopy of Asymptomatic Patients over 40 yrs. old.	
Total routine proctoscopies	448 patients
Total unsuspected positive findings	25 patients
Benign Polyps	23 patients (5.1%)
Carcinoma	2 patients (0.46%)
Proctoscopic Examinations of Patients with Rectal Symptoms	
Number of Diagnostic Proctoscopies	98 patients
Total Positive Findings	15 patients
Unsuspected Benign Polyps	12 patients (12%)
Unsuspected Carcinoma	3 patients (3%)

All were unsuspected Positive Findings in Addition to the Known Hemorrhoids, Fistulas, Fissures, Condylomata, etc. for which they were admitted.

motic suture line recurred within two years. The other two were corrected by a jejunal interposition operation; but this is a difficult procedure. These have been done too recently for me to evaluate the permanent results.

There were two other older patients with strangulation and perforation of their hiatus hernia. Both cases were fatal. It is for these reasons that I advocate that patients with hiatus hernia who have heartburn or other symptoms have their hernia corrected before these complications develop.

Colon and Rectum

Some years ago at the Perry Point Veterans Hospital we commenced the routine of proctoscoping every patient who was over forty years of age and was admitted on the Surgical Service regardless of the nature of his complaints. Proctoscopic examinations of people over forty having no rectal complaints are called routine proctoscopies, while those of people who have some kind of rectal complaint are called diagnostic proctoscopies. The year before last[4] the total of these two groups was 546 patients and there were positive findings requiring biopsy in forty patients or 7 per cent (Table 6).

Routine proctoscopic examinations of patients over forty having no rectal symptoms totaled 448 with unsuspected positive findings requiring biopsy in 25 patients, almost 6 per cent. Of those 25, unsuspected benign polyps were found to be present in 23. We consider these lesions to be premalignant. However, in addition there were two patients with unsuspected carcinomas.

There were 98 diagnostic proctoscopies on patients sent in with some known rectal condition. In this group there were 15 patients with positive findings that required biopsy. Twelve of these were unsuspected benign polyps, and three were unsuspected carcinomas. These were all unsuspected positive findings in addition to the known hemorrhoids, fistulas, etc. No suspected carcinomas or polyps are included.

We compared these results with the usual routine examinations made on 100 consecutive patients admitted to the surgical service (Table 7).

TABLE 7
Unsuspected Pathology Discovered by Usual Routine Examinations in 100 Patients

1. Complete blood count	0
2. Urinalysis	1 (Same as 5)
3. Serology	0
4. Blood urea nitrogen	0
5. Fasting blood sugar	1 (Same as 2)
6. Temperature, pulse, respiration and blood pressure	3
7. Percussion and auscultation of the Chest	0
8. Chest x-ray	1
9. Proctoscopy	5

In this group only five had unsuspected conditions picked up by the usual routines, while the same number were picked up by proctoscopy as by the total of all the other routines. We believe that routine proctoscopy for patients over forty is worthwhile. I should like to add that 14 of our last 39 resections for carcinoma of the colon and rectum were picked up by routine proctoscopy. It is a particularly valuable procedure for a senior resident in surgery to establish, especially if a junior resident is assigned all the proctoscopics. It will increase the number of carcinomas found to be operated upon.

continued on next page

TABLE 8
Operations for Mid-rectal Carcinoma

	Miles Operation		Sphincter Preserving Operation	
	Cases	5-yr. Survival	Cases	5-yr. Survival
Best and Rasmussen[5]	112	54.5%	93	55.5%
Waugh and Turner	182	51.1%	131	52.7%

At present there is great difference of opinion as to the proper treatment of carcinomas of the rectum situated more than 5 cms. but less than 20 cms. above the anus. There is general agreement that all situated more than 20 cms. above the anus should be treated by anterior resection, and all situated 5 cms. or less above the anus should be treated by a Miles abdomino-perineal resection with a permanent colostomy. The dispute about those situated in between concerns whether they should be treated by some form of a sphincter preserving operation.

Some comparative figures for the two methods, each series having been operated upon by the same group of surgeons, are shown in Table 8.

The five-year survival is about the same in both groups. There are other series that support these findings. No one argues that a sphincter preserving operation is a better cancer operation than a Miles procedure, but if both give the same results it is as far more convenient for the patient to have an intact sphincter.

I have had a limited experience with what I call the Best Operation popularized by Doctor Russell Best in Omaha. It consists of mobilizing the colon and rectum through the abdomen just as for a Miles resection. Then, after turning the patient over, going through the perineum, pulling down the mobilized segment, and resecting it above and below the tumor, the rectal stump is anastomosed to the proximal end of the colon that is remaining. Actually the dissection is just exactly the same as for a Miles with the exception that the sphincter is left intact. I have operated on nine such patients. One patient died three years later with metastases, the remaining eight are still living and seven of these are apparently well three to six years after the operation. One, a female, had a local recurrence two years later at the suture line, and this was treated by a secondary Miles procedure. She is still living, but has metastases. I am very satisfied with the procedure and continue to perform it on those carefully selected patients.

Recurrence of a rectal carcinoma after a Miles operation is considered to be hopeless as far as further treatment is concerned. That is usually true but there are exceptions which encourage one to keep on trying to relieve these patients. Two women had local recurrence in the area from which their rectum had been removed by a Miles resection. Both were subsequently treated by Brack's radium plaque with gratifying results. One is still living and apparently well nine years after radium treatment. I am sorry to say that this month, seven years later, the first patient has evidence of local recurrence and is now being treated by cobalt radiation.

Peritoneoscopy

Peritoneoscopy is a valuable procedure which is not used as much as it deserves to be. It is done under local anesthesia and disturbs the patient very little. A pneumoperitoneum is created first, followed by insertion of the scope, re-inflation of the abdomen with air so as to provide more room for maneuvering the instrument, and then observation of the liver, omentum, peritoneal surfaces and pelvic organs. It is particularly valuable for determining the causes of ascites and of hepatomegaly.

The cases should be carefully selected and there are three contraindications. These are adhesions from previous operations, abdominal distention, or the presence of acute inflammatory disease within the abdomen.

Table 9 shows the percentage of successful examinations and the complications in our first 120 cases. We have now done over 700.

TABLE 9

Satisfactory Peritoneoscopies		115
Correct Diagnosis		103
Cirrhosis of Liver	25	
Combined Cirrhosis and Tuberculous Peritonitis	1	
Normal Liver and Peritoneum without metastases	19	
Metastases, source invisible	18	
Carcinoma of Ovary, inoperable	7	
Carcinoma of Ovary, operable	2	
Hepatitis	8	
Tuberculous Peritonitis	5	
Ectopic Pregnancy, Present	2	
Absent (1 positive Friedman's test)	2	
Myomatous Uterus, post-menopause	1	
pre-menopause	1	
Ovarian Cyst	2	
Primary Hepatoma	2	
Peptic Ulcer	2	
Carcinoma of Gall Bladder	1	
Obstructive Jaundice due to Stones	1	
Retroperitoneal Tumor	1	
Chronic Passive Congestion of Liver	2	
Hodgkins of Liver	1	
Incorrect Diagnoses		12

Ninety per cent of the examinations were satisfactory; the incidence of complications was 5 per cent and the mortality rate was 0.8 per cent (see Table 10).

TABLE 10

Total Patients Peritoneoscoped		120
Unsatisfactory Peritoneoscopies (Adhesions)	5	
Satisfactory Peritoneoscopies	115	
With biopsy	49	
Without biopsy	66	
Complications	6	
Perforated Bowel	1	
Perforated Gall Bladder	1	
Hemorrhage from Abdominal Wall (Fatal)	1	
Postoperative Emphysema	1	
Exacerbation of Symptoms (Fever)	2	
Deaths	1	

concluded on page 357

Editorials

SCIENCE FAIR, 1961

THE SIXTEENTH ANNUAL Providence Journal-Bulletin Science Fair opened its doors at Marvel Gymnasium to the public the day after Easter. Once again the people of the state flocked to see, admire, and learn from the scientific efforts of our junior and senior high school students. The exhibits ranged widely over fields of current interest in electronics and physics, mechanics, geology, meteorology, botany, and biology. The students' ingenuity, showmanship, insight, and occasional scientific sophistication were impressive. The Rhode Island Medical Society contributed its support to the stimulating event by making six awards to students demonstrating medical and public health exhibits. These medical award winners were further honored at the Annual Meeting of the Society, when they were presented government bonds in recognition to their achievements.

The Society clearly has an obligation to foster scientific interest and education among our young people, particularly in medically related fields, at a time when applications to medical schools seem to be declining in both quantity and quality. We must continue to make the science and practice of medicine an attractive, exciting prospect for students. While there have been objections raised to science projects as frivolous distractions to the basic high school curriculum where excellence is most to be desired, still the creative development of good exhibits seems to encourage the excitement and motivation for the long, laborious pull necessary to basic scientific education. On balance the Science Fair seems to provide an excellent opportunity for encouragement of prospective scientists and, we hope, prospective doctors. We are indebted to Brown University and to the Providence Journal Company for sponsorship of a worthwhile and desirable activity of value to the community and the medical profession.

Rhode Island Medical Society Science Fair winners at the 150th annual meeting of the Society. (l-r) – Peter Arnold, Arlene Antonian, Mary Flannagan, Carol Ann DeAngelis, Charlene Miga, and William Darby.

... PROVIDENCE JOURNAL-BULLETIN Photo

NEW ENGLAND HEALTH

NEW ENGLAND has always seemed a distinct cultural as well as geographical entity. The rock-bound coast, hard-scrabble farms, elm-shaded streets, and town-meeting governments have molded the people and formed a traditional atmosphere of independence and individuality not found elsewhere. We like to think that New England is distinctive in temper, flavor, and character; but in twentieth century America the old flavor seems a remembrance of things past, long lost to modern organization and communications and to the scientific revolution. Recent government health statistics, however, provide a surprising rebuttal to the concept that New England is just another small slice of the American pie.

From July, 1957 through June, 1959 the U.S. Public Health Service conducted a sampling of American households, asking questions about chronic disease, accidents, and medical attention for the U.S. National Health Survey. These data are published as part of PUBLIC HEALTH SERVICE PUBLICATION No. 584 (Series C, No. 6). In the tables

continued on next page

of figures New England with surprising regularity occupies an extreme position among the eight regions into which the nation is divided for this survey. Consider eleven chronic diseases investigated: New England is in the extreme position in seven of them with the highest rate of any region in the country for heart conditions, peptic ulcer, hernia, and impaired hearing. However, it has the lowest incidence of arthritis and rheumatism, chronic bronchitis, and chronic sinusitis. High blood pressure, diabetes, asthma, and visual impairment show intermediate rates. Generally some form of chronic disease is reported by approximately 40 per cent of the population of the United States with about 10 per cent showing some degree of activity limitation on that account. This same incidence is found in New England which, however, has the oldest population of any section of the country. Ten per cent of New England people are sixty-five or over. But New Englanders don't go to bed for long when they are sick. The rate for bed-disability is 5.3 days per person per year, the lowest rate in the nation. And 5.5 days lost from work, per person per year, is also the lowest rate in the nation. Americans on the average consult a physician five times a year and a dentist 1.5 times a year, but in New England physician consultations are comparatively low at 4.3 visits per year, while an incidence of 1.8 dental visits is about average. New England is the last bastion of the medical home visit. Seventeen per cent of all medical visits here are house calls compared with 14 per cent in New York, New Jersey, and Pennsylvania, and less than 10 per cent in all other regions.

As cynics have observed before: "there are lies, damned lies, and statistics." In defense of a statistical presentation it can be said that at times no other method illuminates comparisons so clearly. The health statistics of the U.S. National Health Survey indicate that the New England population is older, has a unique pattern of chronic disease, goes to bed sick for a shorter time interval, loses fewer work days from sickness, and consults physicians less often than other American regional groups. But statistics don't explain why. We prefer to believe that New Englanders are still tough, independent, and individualistic. We hope that the high rate of hearing loss reported doesn't mean they didn't hear the questions asked.

BABIES AND BREADWINNERS

We are living in an age of slogans and "gimmicks" and it is no surprise to learn that the United States Public Health Service has succumbed to the seductive siren song of the hucksters. A recent pamphlet titled, *Babies and Breadwinners* issued by the USPHS has outlined the 1961 campaign, designed to stimulate interest in the immediate immunization of all individuals against poliomyelitis.

It is now recognized that the well-publicized oral vaccines (either Cox or Sabin) will not be available in the Rhode Island area before the polio season is upon us; consequently we must content ourselves with the Salk vaccine which has, we feel, broken the back of the polio scourge.

Again this year the physicians of Rhode Island have been asked to help and indeed it is impossible for any successful attack to be launched without the co-operation of the medical profession. The House of Delegates of the Rhode Island Medical Society has endorsed the principle that necessary clinics be approved by the district component medical society in the area in which such clinics are to be held. The Rhode Island Department of Health has offered free vaccine to all physicians and properly endorsed clinics, and the department has set up a Polio Advisory Committee which advises with Doctor Joseph E. Cannon, the director.

Doctor Frank Fratantuono, president of the Providence Medical Association, handled the situation rather well, we think. He asked for, and readily secured, volunteers to help staff clinics in the Providence area for two separate weeks. He stated: "Once this program is completed, it is the opinion of your Association that all Providence residents then should seek any further immunizations at the offices of their individual physicians." This principle is basically sound and is applicable on a statewide basis.

ARE THEY FIGHTING THE WRONG WAR?

In a recent issue of the New York Times (April 16, 1961) it was reported that "a vast array of complex new regulations governing the drug industry have been handed down by the government and drug officials complain that conforming to these directives is proving to be a costly and difficult business." It was also reported that the problems of the ethical drug industry were further compounded by the introduction of sweeping new legislation by Senator Estes Kefauver of Tennessee and Congressman Emanuel Celler of New York aimed at "curbing alleged abuses in the drug industry." Senator Kefauver's bill would bring about important changes in the manufacture and sale of pharmaceuticals in the United States. It provides that new drugs shall be tested by the government for their effectiveness in addition to their safety. They are presently tested only for safety. Drug manufacturers would be licensed and their plants more thoroughly inspected. Holders of drug patents would be required to license them to other manufacturers after three years (fourteen at present). In addition, the government would be ordered to devise an official list of names of important drugs, thus encouraging doctors to use *generic*, rather than trade names. And finally President Kennedy indicated he might through executive order act to combat high drug prices "and other abuses." One drug company executive was quoted as saying, "We've had a sheltered life for years, but we're really in for a bad time now."

Recently, moreover, the Federal Food and Drug Administration has imposed drastic new regulations requiring full disclosure not only of a drug's indications, but also of its demonstrated and potential side effects. But these latter regulations appear mild in comparison to the proposed new legislation. Although many of these measures are undoubtedly desirable, even overdue in some instances, it would appear to us that the net effect will actually be further increases in the cost of legitimate drugs.

In all this sound and fury, however, we detect a faint odor of politics, even of hypocrisy. Nowhere in all the smokescreen of solicitude for the welfare of the public is there a word of concern about the manifest abuses of that disgraceful multi-million-dollar scourge upon our civilization, the offensive and malodorous patent medicine industry. No newspaper, no magazine, no commentator, no columnist, nor any politician has demonstrated the backbone to speak out against this vicious parasite upon the innocent public or to recommend its drastic elimination or regulation. Nor does anyone holding public office manifest the least interest in the continuous extraction of hundreds of millions of dollars annually by the sale of useless and even harmful nostrums, promoted shamelessly and offensively through the press and television. In view of the conspiracy of silence in this vital matter we can only assume total lack of courage or outright venality.

REGARDING HYPNOSIS

A Statement of Position by the American Psychiatric Association

February 15, 1961

Many inquiries requesting an official opinion of the American Psychiatric Association on hypnotic therapy have been received from local psychiatric and other medical societies and from individual members of the Association and others. These inquiries, in general, ask the following questions: Is hypnosis an acceptable psychiatric procedure? If so, who should teach it? To whom should it be taught? What should be the depth and extent of such teaching? Where can adequate training be secured?

The following statement of position regarding these matters has been prepared by the Committee on Therapy of the American Psychiatric Association and is published with the approval of the Council of the Association for the information and guidance of all concerned.

Statement

Hypnosis is a specialized psychiatric procedure and as such is an aspect of doctor-patient relationship. Hypnosis provides an adjunct to research, to diagnosis and to treatment in psychiatric practice. It is also of some value in other areas of medical practice and research.

Unfortunately, so little is known of the nature of the hypnotic state that definitions usually reduce themselves to mere descriptions of the various manifested phenomena. Few reports of controlled experiments into the nature of hypnosis have been published.

Hypnosis is appropriately and properly used in the course of therapy only when its employment serves therapeutic goals without posing undue risks to the patient. With selected patients, it can be used for sedative, analgesic and anesthetic purposes; for the relief of apprehension and anxiety; and for symptom suppression. It can also be used, but on a still more highly selective basis, as an adjunct in the treatment of patients with neurotic or psychotic illness.

Hypnosis or hypnotic treatment, as in any other psychiatric procedure, calls for all examinations necessary to a proper diagnosis and to the formulation of the immediate therapeutic needs of the patient. The technique of induction of the trance state is by far the least important of the many facets of the hypnotic procedure and under no circumstance should it be taught independently.

Whoever makes use of hypnotic techniques, therefore, should have sufficient knowledge of psychiatry, and particularly psychodynamics, to avoid its use in clinical situations where it is contraindicated or even dangerous. Although similar dangers attend the improper or inept use of all other aspects of the doctor-patient relationship, the nature of hypnosis renders its inappropriate use particularly hazardous. For hypnosis to be used safely, even for the relief of pain or for sedation, more than a superficial knowledge of the dynamics of human motivation is essential.

Since hypnosis has definite application in the various fields of medicine, physicians have recently shown increasing interest in hypnosis and have turned to psychiatrists for training in hypnosis.

To be adequate for medical purposes, all courses in hypnosis should be given in conjunction with recognized medical teaching institutions or teaching hospitals, under the auspices of the department of psychiatry and in collaboration with those other departments which are similarly interested. Although lectures, demonstrations, seminars, conferences and discussions are helpful, the basic learning experience must derive from closely supervised clinical contact with patients. Since such psychiatrically centered courses are virtually non-existent, many physicians have enrolled in the inadequate brief courses available, which are taught often by individuals without medical or psychiatric training. These courses have concentrated on hypnotic-trance techniques and have neglected or covered psychodynamics and psychopathology in a superficial or stereotyped fashion.

Proper safeguards for the use of hypnosis are vitally important to the patient, to all physicians, and to psychiatry as a specialty. In the interest of encouraging the safe use of hypnosis, the following recommendations are approved.

Recommendations

1. Isolated courses limited to the teaching of trance induction techniques are strongly disapproved.
2. The teaching of hypnosis should take place in medical schools and other psychiatric training centers that have an interest in the teaching of hypnosis. When taught in such a climate, where students can acquire adequate knowledge of psychiatric principles, hypnosis may become a useful adjunct to therapy.

3. The teaching of hypnosis should be of sufficient duration and depth for students to acquire adequate understanding of its appropriate place in relation to other psychiatric treatment modalities; of its indications and contraindications; of its values and its dangers. Decisions regarding the depth and extent of the teaching of hypnosis should remain flexible, and should be made by the psychiatric departments teaching such courses.
4. Training in all aspects of hypnosis should be made available to physicians and dentists requesting it.
5. An expansion of facilities for the teaching of hypnosis is needed particularly at the postgraduate level. The establishment of postgraduate courses in medical schools and other teaching centers under the direction of the department of psychiatry is recommended.
6. Physicians practicing hypnosis should do so only in their particular field of medical competence.
7. The need for continued study of hypnosis and for adequate research is emphasized, with particular reference to delineating its place in the total treatment program.

GASTROINTESTINAL SURGERY

concluded from page 352

When you consider that a large percentage of these patients were peritoneoscoped because they were considered to be too sick to withstand an exploratory operation, the record is good. Furthermore, we have not had any other deaths in the much larger series up to the present.

The procedure has provided the diagnosis in a variety of different conditions as shown in Table 9. We believe it to be a valuable diagnostic aid in highly selected cases.

This concludes my evaluation of selected gastrointestinal conditions with which we have had personal experience, and about which we have developed personal opinions. I believe that you will agree that many problems in this field still await a solution.

BIBLIOGRAPHY

[1]Shackelford, R. T.; Wood, S. Jr.; and Boitnott, J. K.: Primary Sarcomas of the Stomach. Am. J. Surg. 101:292, March 1961

[2]McDermott, W. V.; Palazzi, H.; Nardi, G. L.; and Mondet, A.: Elective Portal Systemic Shunt: An Analysis of 237 Cases. New England J. Med. 264:419, March 2, 1961

[3]Shackelford, R. T., and Marcus, W. Y.: Jejunal Diverticula — A Cause of Gastro-Intestinal Hemorrhage: A Report of Three Cases and Review of the Literature. Ann. Surg. 151:930, June 1960

[4]Shackelford, R. T., and Linn, B. S.: An Evaluation of Routine Proctoscopic Examination of Asymptomatic Patients Over 40 Years Old. Memphis and Mid-South Med. J. 35:271, July 1960

[5]Best, R. R., and Rasmussen, J. A.: Sphincter-preserving Operations for Cancer of Rectum; Special Reference to Incidence and Survival Rates. A.M.A. Arch. Surg. 72:948, 1956

[6]Waugh, J. M., and Turner, J. C. Jr.: A Study of 298 Patients with Carcinoma of the Mid-rectum treated by Abdomino-perineal resection with Sphincter Preservation. Surg., Gyn. and Obst. 107:777, 1958

BOOK REVIEW

STROKE. A Study of Recovery by Douglas Ritchie. Doubleday & Co., Inc., Garden City, N.Y. 1961. $3.50

How does a successful man, a man with a promising future, react when suddenly he suffers a stroke, leaving him speechless and paralyzed? Douglas Ritchie, a famous commentator for the BBC in England, now faces years of indecision, pain, and perhaps the most destructive of all, depression. So many things that had been routinely done suddenly became arduous tasks. Yes, he had "the abilities of a child and the sensibilities of a man," as the book so very well phrases it. When told by a physician that he must do more than exercise his muscles, he turned to writing a diary to regain and develop his powers of concentration; the result after three years is STROKE. Yes, Mr. Ritchie has indeed written an inspiring book about a worthy and courageous subject — himself.

ANNMARIE SAVONE

ANNUAL BUSINESS MEETING
of the
RHODE ISLAND MEDICAL SOCIETY
May 3, 1961

THE INSTALLATION of officers and elected committees to serve the Society for the Sesquicentennial Year ending in May, 1962, the adoption of an amendment to the by-laws to change the Committee on Public Relations and Information to a five-member committee, and the election of Miss Grace E. Dickerman, *librarian emerita* as an honorary member of the Society, featured the general business meeting held during the 150th annual session, on May 3, 1961.

Officers Elected

Doctor Samuel Adelson, Newport surgeon, was installed as the 102d president of the Rhode Island Medical Society, the nation's ninth oldest state medical association. He succeeded Doctor Earl J. Mara of Pawtucket, and he becomes the first Newport physician to be elected president of the state medical society in a thirty-four-year span. Doctor Norman H. McLeod of Newport was elected president in 1927, and in 1943 Doctor Michael H. Sullivan, elected vice president, succeeded to the presidency upon the death of Doctor Murray S. Danforth.

Others elected by the Society were: Doctor Frank I. Matteo, Providence obstetrician, vice president; Doctor Arthur E. Hardy, Warwick surgeon and formerly secretary of the Society, president-elect to succeed Doctor Adelson next year; Doctor Michael DiMaio, Providence internist who succeeds Doctor Hardy as secretary; and Doctor J. Murray Beardsley, Providence surgeon, who was re-elected treasurer.

One-time chairman of the Newport Representative Council, Doctor Adelson brings to the leadership of the state medical society long experience in medical and civic organization work. A graduate of Rogers High School, Tufts College and its medical school, Doctor Adelson established his medical practice in the city-by-the-sea in 1923. He is senior surgeon at Newport Hospital, and in addition to the service as president of the Newport County Medical Society he has served two terms as vice president of the state medical society, and has been active for many years on major committees, and as a member of the Council and the House of Delegates.

His civic record, in addition to his terms of service with the Representative Council, include assignments as secretary of the Newport Board of Health, medical examiner in Newport County, member of the City Charter Commission, and chairman of the Newport High School Commission. His club affiliations include Masonic Orders, the Lions Club, and B'nai B'rith of which he is a past president.

Warwick Native President-Elect

Doctor Arthur E. Hardy, of Warwick, named president-elect of the Society, is a native of Warwick, a graduate of Warwick High, Brown University, and Harvard Medical School. After internships at Chapin and Rhode Island hospitals, he served as resident at the state institutions, and then established his private practice in the Edgewood section of Warwick. Successively secretary, vice president and then president of the Kent County Medical Society, Doctor Hardy has also been active in state medical affairs with major committees, as a member of the Council and House of Delegates, and for the past two years as secretary of the state medical organization. In addition he has been the Society's alternate delegate to the House of Delegates of the American Medical Association for the past eight years.

Doctor F. I. Matteo Named Vice President

Doctor Frank I. Matteo, Providence obstetrician and gynecologist, was elected to succeed Doctor Frank W. Dimmitt as vice president. A native of Providence, a graduate of Classical High, Tufts and its medical school, Doctor Matteo is a past president of the Malpighi Medical Club, and he is currently treasurer of the Providence Medical Association.

Doctor Michael DiMaio, of Providence, named to succeed Doctor Hardy as secretary of the Society, has been a member of the House of Delegates for many years, and he served as secretary of the Providence Medical Association from 1951 until 1959. He is currently a member of the state board of examiners in medicine. He is a native of Providence and a graduate of the University of Rhode Island and of Johns Hopkins Medical School.

Standing Committee Chairmen

Seven major committees, designated as standing committees of the Society whose personnel is elected by the House of Delegates, were elected with the following as chairmen: Industrial Health, Doctor Thomas J. Dolan, of Providence; Library, Doctor Francesco Ronchese, of Providence; Medical Economics, Doctor Stanley D. Simon, of Providence; Publications, Doctor Alex M. Burgess, of Providence; Public Laws, Doctor F. B. Agnelli, of Westerly; Public Policy and Relations, Doctor Samuel Adelson, of Newport; Scientific Work and Annual Meeting, Doctor Jesse P. Eddy III, of Providence.

By-Law Change Adopted

A suggested by-law change proposed by the House of Delegates of the Society was adopted by the membership at the general meeting without dissent. The change was proposed to permit prompt action by the officers of the Society as the official spokesmen in matters involving the profession and the public. Under the new arrangement the president, the president-elect, and the secretary become permanent members of the committee, and each year the House will elect two additional members to serve with these officers. The complete amendment as adopted is as follows:

"*SECTION 11.* **PUBLIC POLICY AND RELATIONS. The Committee on Public Policy and Relations shall consist of five (5) members, of whom three shall be the president, the president-elect, and the secretary of the Rhode Island Medical Society, and two members elected by the House of Delegates. The Committee shall concern itself with all matters of public policy, public relations, and information relative to medicine and public health."**

Miss Dickerman Elected Member

Miss Grace E. Dickerman, *librarian emerita* of the Society, was elected to honorary membership upon recommendation of the Council, and the election won unanimous approval by the members in attendance at the general meeting on May 3.

A native of South Norwalk, Connecticut, Miss Dickerman entered the Society's employ in 1903 as assistant to Doctor George D. Hersey, then librarian, and she had charge of the medical volumes of the Society that were stored at the Providence Public Library. When the Society acquired its own building on Francis Street, Miss Dickerman became acting librarian, and later librarian upon the death of Doctor Hersey. She held the post until her retirement to the status of *librarian emerita* in 1945.

In 1953, the Rhode Island Medical Society conferred a special citation to Miss Dickerman in recognition of her half century of outstanding service to the medical profession. Her election to honorary membership was announced at the annual dinner May 3 by Doctor Earl J. Mara, president. A framed membership certificate was accepted for the Society's newest member by Mrs. David DeJong, current librarian, as Miss Dickerman was unable to be in attendance at the session.

In addition to the membership award the Society also presented Miss Dickerman with a television.

May 8 and 9, 1962

151st ANNUAL MEETING

THROUGH . . .  *the Microscope*

Blue Shield Plans Business Meeting Actions Far Reaching

The 1961 annual business meeting of the Blue Shield Plans held in Chicago, April 16-18, was one of the most active and progressive sessions ever held, according to NEWSLETTER, official publication of the Association, and it was marked by a series of developments which will undoubtedly have a tremendous effect upon the future of Blue Shield.

Primary among these developments was the adoption of a proposal which, when implemented, will enable Blue Shield Plans to offer an entirely new uniform program on a national basis. This new Blue Shield program is one of the most significant achievements in the history of Blue Shield and will equip the organization to compete with full effectiveness for the first time in the enrollment of companies whose operations and employees are located in widely separated areas across the nation.

The most important aspect of the new program is the method developed to establish the payments for covered services to be provided. This method was arrived at by means of an exhaustive analysis of all existing Blue Shield benefit payments to determine a means of deriving benefit schedules that would be applicable on a nationwide basis. The study ultimately produced a method of devising benefit schedules adaptable to local administration and prevailing local costs in any number of Blue Shield Plans anywhere in the country.

The new nationwide program, when made available, will supplement existing Blue Shield offerings for local groups and will in no way conflict with local Plan operations. On the contrary, the program will simply extend the capability of individual Plans to serve national accounts on a more competitive and realistic basis than is presently possible under the more or less inflexible system of attempting to fit varying local programs to a situation in which uniformity is essential.

The new Blue Shield program is a progressive move forward, NEWSLETTER maintains, which will enable Blue Shield to meet in a dramatic fashion a growing demand among national employers for better forms of health benefits coverage.

Social Security Facts and Figures

The Social Security Administration issued a news release on March 20 which shows that the Old Age and Survivors Insurance Trust Fund continues to squeak at the seams. . . . The release stated that in 1959, the OASI program operated at a deficit of $1.7 billion, which reduced the OASI Trust Fund from $21.8 billion to $20.1 billion. . . . It was then pointed out that in 1960, the program operated at a surplus of $184 million, and that in 1961 a surplus of $18 million is expected. . . . The surplus in 1960 occurred because the social security tax was upped to 6% (3% employee, 3% employer) last year. . . . What the release did not point out although figures accompanying the release did, was that the fund would again have a deficit year in 1962 to the tune of $407 million. . . . The 1962 deficit would bring the trust fund below the $20 billion mark -- this from an all-time high in 1956 of $22.5 billion. . . . And these projections are made on the premise that Congress will not increase social security benefits.

It is interesting to note that from 1958 to 1960, the Trust Fund declined at a rate of $800 million a year. . . . Previously, Robert J. Myers, chief actuary for the Social Security Administration, had estimated a lowest average decline from 1958-65 of $300 million a year. . . . Thus, while 1959-60 were fair employment years, the fund declined faster than Myers' lowest estimate. . . . Now, if the Social Security Administration is again estimating a deficit in 1962, the figures are falling far below Myers' most pessimistic forecast of 1958. . . . The Social Security Administration maintains that the Trust Fund will increase beginning in 1963 when another boost in the tax is scheduled.

Unions Campaign to Organize Federal Employees

Harry J. Lambeth, in his column on the *Washington Labor Whirl* for the U.S. Chamber of Commerce reports that if the old saying, "Where

continued on page 362

Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 10th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 50,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife, for whom a special program is planned.

ANOTHER YEAR OF SYMPOSIA . . .

RICHARDSON SPRINGS, CALIFORNIA
Sunday, June 11, 1961
Richardson's Mineral Springs

SPRINGFIELD, MASSACHUSETTS
Wednesday, June 14, 1961
The Schine Inn

CHEYENNE, WYOMING
Monday, July 24, 1961
The Plains Hotel

McALESTER, OKLAHOMA
Saturday, July 29, 1961
The Aldridge Hotel

SEATTLE, WASHINGTON
Saturday, August 5, 1961
The Olympic Hotel

KANSAS CITY, KANSAS
Friday, September 15, 1961
Battenfeld Memorial Auditorium

TOLEDO, OHIO
Thursday, September 28, 1961
The Commodore Perry Hotel

WICHITA, KANSAS
Wednesday, October 4, 1961
The Broadview Hotel

TRAVERSE CITY, MICHIGAN
Friday, October 13, 1961
The Park Place Hotel

PEORIA, ILLINOIS
Thursday, October 26, 1961
The Hotel Pere Marquette

PROVIDENCE, RHODE ISLAND
Wednesday, November 1, 1961
The Colony Motor Hotel

HARRISBURG, PENNSYLVANIA
Thursday, November 9, 1961
The Penn Harris Hotel

JACKSONVILLE, FLORIDA
Sunday, November 12, 1961
The Robert Meyer Hotel

ALLENTOWN, PENNSYLVANIA
Wednesday, November 15, 1961
The Americas Hotel

Lederle **LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.**

THROUGH THE MICROSCOPE

continued from page 360

there's smoke, there's fire," has merit, keep an eye on the union campaign to organize more federal employees and finally force the United States government to bargain with the AFL-CIO.

Union officials know the difficulty of getting Congress to pass legislation requiring the government to recognize employee unions as the exclusive bargaining agent for all federal employees. They have pinned their hopes on persuading President Kennedy to issue an executive order requiring government departments to bargain. Once this is achieved, the unions will demand a check-off contract clause whereby the American taxpayers will be paying the cost of collecting union dues. The WASHINGTON STAR has reported that a preliminary draft of an executive order is now being circulated among officials of the Labor department and the Civil Service Commission.

At the moment no union boss would dare ask the right to strike, but this can be expected later. The old cry of "discrimination" and "why can't we have the rights other unions have" will be pushed at every opportunity. Back in 1937, however, President Roosevelt told the National Federation of Federal Employees that "government employees should realize that the process of collective bargaining . . . can't be transplanted into the public service."

Meantime the government unions are pushing their organization drive. Since February, they claim to have rounded up 2,000 new members in Washington.

Deadly Reckoning

Compilations by the Travelers Insurance Companies show that persons killed last year in highway accidents which were blamed on excessive speed totaled 10,970 as compared with 12,980 in 1959. This report is included in the safety booklet published annually by the Travelers since 1931 and distributed to more than 3.3 million persons.

"Citizens organizations throughout the country should take heart in these figures," said J. Doyle DeWitt, president of the Travelers. "This decrease in deaths-due-to-speed is even more significant when you realize that it came in a year when highway accidents actually killed 400 more people than a year ago."

The Travelers president pointed out that speed has long been blamed as "the number one killer on our highways."

"Even with the improved speed record last year," Mr. DeWitt said, "speed was listed as the primary cause of accidents which accounted to 36.1 per cent of the total deaths. As for injuries, the record was not as good. They increased nearly 100,000 with more than 1,000,000 blamed on speed during the year."

Health Plans Cover Long Hospital Stays

Hospital expense provisions of new group health insurance policies now most commonly provide daily hospital room-and-board benefits of $15 or more, and maximum hospital stays of more than two months, the Health Insurance Institute reported recently.

The Institute said its report was based on an analysis of data supplied by insurance companies which were responsible for 68 per cent of the total group health insurance premiums in the United States in 1959. The data sampling consisted of some 1,400 new group hospital expense policies issued during 1960 protecting more than 170,000 employees and most of their families.

These hospital expense coverages provided more than half the employees (54 per cent) with daily hospital room-and-board benefits of at least $15, said the Institute. About three out of every ten workers had daily room-and-board benefits of $18 or more, and one out of four employees had benefits of $11 to $14 a day, the Institute stated.

It was pointed out by the Institute that hospital rates vary greatly by area, reflecting living costs in local communities and the range of services provided.

This was borne out, said the Institute, by a survey in 1959 which showed that the average charge for a bed in a two-bed semi-private room was $25.40 in Los Angeles, and $14.44 in Dallas. Thus, a policy with a $10 benefit in Dallas could actually cover more of the room-and-board portion of a hospital bill than a policy with a $20 benefit in Los Angeles, the HII declared.

When it came to duration of hospital stay, said the Institute, the group hospital expense coverages issued last year provided maximum stays of 31 days or more to 99 per cent of the employees.

Some 56 per cent of the workers had available maximum stays of 70 days or more, while some 20 per cent had maximums of 120 days or more. Other maximum stays were for 150 days, 180 days and 365 days. Some of the policies did not specify a maximum stay but instead had an over-all limit on the combined amount payable for both room-and-board and miscellaneous hospital services.

New Radio-Electrocardiograph Instrument Developed

An offshoot of the United States' successful Astronaut program is expected to provide a major breakthrough in the diagnosis of cardiac disorders, it was revealed at the tenth Annual Convention of the American College of Cardiology held in New York last month.

Physicians at the meeting saw demonstrations of

a new, simplified radio-electrocardiograph system which, for the first time, makes practical the taking of electrocardiograms in doctors' offices or hospitals while patients are exercising.

The new instrument consists of a pocket-sized transmitter which broadcasts a patient's heartbeats to a receiver, as far as 500 feet away. The receiver relays the information to an oscilloscope, electrocardiogram recording machine or tape recorder for medical interpretation.

The lack of any connective wiring between the patient and the recording instruments permits freedom of movement prohibited with previous EKG equipment.

Retired Federal Employees Enrolled in Health Benefits Plan

The Civil Service Commission has tabulated the preliminary results of the enrollment under the Retired Federal Employees Health Benefits Program.

Under this program, the government contributes toward the cost of an annuitant's health benefits coverage $6 a month for a family enrollment and $3 a month for a self-only enrollment. If an annuitant elects to continue in a qualified private health insurance plan, the government contribution will be added to his annuity check to help him pay the cost of that coverage. If the annuitant elects to enroll in the Uniform Plan, for which the Commission is contracting with the Aetna Life Insurance Company, the contribution will go to help pay for the cost of that coverage, with the annuitant's share of the cost being deducted from his monthly annuity check.

The preliminary results show that 126,000 annuitants elected to enroll in the Uniform Plan. Of these, 68,000 enrolled for self-only and 58,000 took family enrollments. A further breakdown of these elections shows the type of coverage chosen under the Uniform Plan:

Self Only	
Basic Coverage	24,000
Major Medical Coverage	14,000
Basic Plus Major Medical	30,000
Family	
Basic Coverage	30,000
Major Medical Coverage	11,000
Basic Plus Major Medical	17,000

Some 91,000 annuitants elected to have the government contribution added to their annuity checks to help pay for coverage with private plans. Of these, 38,000 claimed the $3 government contribution for self-only enrollment and 53,000 claimed the $6 a month for family enrollment.

Over 36,000 annuitants elected not to participate in the program at this time.

Coverage for those annuitants who elected to participate in the program will begin on July 1. However, under its regulations the Commission will continue to accept enrollments indefinitely from those annuitants who have not yet elected. A late election will not become effective until the first day of the fourth month following the one in which it is received.

Medical Technology Degree Program Established

The first medical technology degree program in New England was established this year at Northeastern University in Boston. The program is the only one in the nation that is not in a medical school, according to Doctor Nathan W. Riser, chairman of the University's biology department, as reported in a report issued by the New England Board of Higher Education.

The curriculum combines two full years of training in medical technology at the New England Deaconess Hospital with academic work necessary for the Bachelor's degree. The program is a cooperative one, with the student alternating periods of classwork with paid hospital experience.

Hospital Charges Average $15 to $20 Per Day Across the Nation

Charges for basic hospital services — room, board, routine nursing care and minor supplies — average from $15 to $20 a day in hospitals across the nation, a new American Hospital Association survey has shown.

Rates vary widely according to type of accommodation, hospital size, and ownership, and geographic area. More than half of all beds (54 per cent) are in accommodations within the range of $12 to $20 per day; an additional 27 per cent from $20 to $28. Fifteen per cent are below $12 and only 4 per cent are $28 or over.

The new survey, *Daily Service Charges in Hospitals, 1960,* deals with figures obtained from 4,692 short-term nonfederal hospitals, 94 per cent of 5,455 such hospitals listed by the AHA. The hospitals have 543,758 beds.

The new survey, an outgrowth of earlier "room rate" surveys conducted by the Association, is more accurate and specific than previous studies. It will provide a new benchmark for comparisons of charges in future years, the report said.

Although figures in the new survey cannot really be compared with figures in the earlier ones, a general increase in average charges was noted. The report said this increase "probably reflects not only rising hospital costs but also a trend toward a more realistic balance between charges for routine daily services and unit charges for special services."

Ninety, or 2 per cent, of the 4,692 hospitals use inclusive rate systems with a single charge covering both routine daily services and special services.

concluded on next page

Three geographic areas — New York City, Cleveland and California — accounted for 54, or 60 per cent, of these inclusive rate hospitals.

Average daily charges for all hospitals, according to accommodation, were as follows: single-bed, $20; two-bed, $17.50; three-bed, $16; four-bed, $15.80; five-bed, $15, and six or more-bed, $15.10.

The total beds in two-bed accommodations accounted for nearly 44 per cent of all beds in the surveyed hospitals, a far greater proportion than in any other category.

The proportion of two-bed accommodations was greatest in the East North Central, West North Central, and Mountain areas. In single beds, the West South Central states led with 38 per cent of their beds in single-bed rooms.

The proportion of beds in accommodations with six or more beds was sharply higher in the New England and Middle Atlantic regions, in hospitals of 500 beds or more, and in hospitals under state, city and county auspices.

Geographically, the highest average charge for all accommodations was found in the Pacific region, with New England a close second; the lowest averages were in the West South Central states.

Among hospitals classified by number of beds, there was a steady and marked increase in average charges with increasing size of hospitals for three categories: single-bed, from $13 in hospitals of less than 25 beds to $24.50 in hospitals with 500 or more beds; two-bed, from $12.40 to $19.20, and four-bed, from $11.90 to $18.70.

Bigger VA General Hospitals Planned

Major changes in hospital design will be incorporated in the Veterans Administration's twelve-year, $900,000,000 program for modernization and replacement of its obsolescent hospitals, the VA chief medical director, Doctor William S. Middleton, stated recently.

Doctor Middleton said the changes will result from progress in care of patients with tuberculosis and psychiatric illness and from the increasing application of automation in medicine.

The trend is away from special hospitals for psychiatric and tuberculous patients and toward the general hospital which can care for these patients as well as general medical and surgical patients.

VA has already converted nine of the agency's TB hospitals to general medical and surgical use, and units for treatment of patients with chronic nontuberculous pulmonary disease have been incorporated into the planning for VA hospitals.

Doctor Middleton said the large psychiatric hospital with its dormitories is a "relic of the past," and even the presently-projected 1,000-bed hospitals for the mentally ill appear unwieldy.

"Psychiatric units are being planned for VA general medical, surgical, and neurological hospitals, and units of medical, surgical, and neurologic beds are being incorporated in VA psychiatric hospitals," he said.

BOOK REVIEWS

SURGERY IN WORLD WAR II. THE PHYSIOLOGIC EFFECTS OF WOUNDS by The Board for the Study of the Severely Wounded, North African-Mediterranean Theater of Operations. Medical Department, United States Army. Wash., 1952. $3.50

This is a unique book for a number of reasons. Several of the members of the Board are well known to doctors in this area, namely the late Tracy B. Mallory (chairman), Henry K. Beecher, and Fiorindo Simeone. It is one of several volumes that make up the monumental work, SURGERY IN WORLD WAR II, produced by the Historical Section, Army Medical Service. Truly, this collection of medical knowledge is unparalleled among recent works, and the whole profession can feel fortunate that such material is available. Who else but the army could collect such an array of talent and share the fruits so generously? For those unable to read the whole series, it is suggested that this book be read as a companion to GENERAL SURGERY IN WORLD WAR II, VOL. II.

The introduction was written by Edward Churchill. It is an excellent summation of the development of surgical experience through World War II, and of the way that evidence was accumulated to bring about radical changes in concepts born during World War I and later. At the beginning of the war, the National Research Council advised that plasma be used as the primary fluid for the treatment of shock. The North African Campaign was barely over before it was realized that the emphasis should have been on whole blood. Similarly, the ideas about shock that were inherited from World War I were largely altered and much confusion and error eliminated. This came about through the work of the resuscitation teams that were organized to prepare the wounded for surgery. Resuscitation thus became the means of bringing the entire care of the wounded into perspective. . . . "Surgery is not only the goal, but in itself is a part of resuscitation," said Beecher.

The accumulating experience thus created a need for organization. It was known that much of World War I knowledge was lost because it had never been properly recorded. This must not happen again. About January, 1944, John D. Stewart (Lt. Col.) made arrangements with others for a small mobile laboratory to be set up near the 11th Field Hospital in Italy. Its purpose was to study by formal biochemical means certain aspects of shock, hemorrhage, and dehydration. Other important work was being done about the same time by Beecher and Burnett at the 94th Evacuation Hospital. These investigations pointed up the need for a formally organized group with the specific purpose of studying the severely wounded. Thus in September, 1944, a Medical Board to Study the Treatment of the Severely Wounded was formally established. This monograph is the result of this study.

The external violence of wounding agents was well known, but the internal state of the severely wounded man was not. The general effect on the entire physiological state was to be investigated. Only the severely wounded, studied as early as possible and as close to the locale of wounding as feasible, were admitted for study. This was done without interfering with the regular care of the wounded or the tactical situation. All conditions were not perfect for the study, but well-documented facts from the 186 men studied were utilized.

The research involved a general evaluation of the physiological state, with special attention to the liver and general pathology. Over half the book is devoted to the kidney in "shock," including the diagnosis and treatment of lower nephron nephrosis, pigment mobilization by the kidney, and the crush syndrome.

Obviously much of this book is a massive compilation of data which is presented in chart and diagram form. But these charts are very direct and easy to comprehend. The prose is, as it should be, "the ordinary language of doctors," and it is smooth reading. Summaries and conclusions end each chapter.

It is a book well-worth reading for all physicians. It is basic medicine, well organized, from a source that is rarely available. We owe a debt of gratitude to these men, but more so to the United States Army, which made it all possible. The National Research Council at the beginning of the war had actually recommended such a study, but had suggested that it be done by men freed of the duties of army officers. Instead, as Churchill writes: "They

continued on next page

were not a group that merely worked in the army, they were of the army."

RAYMOND N. MACANDREW, M.D.

OFFICE GASTROENTEROLOGY by Albert F. R. Andresen, M.D. W. B. Saunders Co., Phil., 1958. $14.00

Doctor Andresen presents in his volume a good deal of common sense advice on the gastrointestinal tract which is unusual for a book of this type. All the practical help and assistance he offers comes from his personal experience of over forty years of teaching and clinical practice. He describes the general concepts of gastrointestinal physiology, pathology, and treatment. Then he considers in detail three types of gastrointestinal disease: 1. Those which may affect any part or all of the gastrointestinal tract; 2. Those which affect only an individual part; and 3. Those which originate elsewhere but produce gastrointestinal symptoms or lesions. Under each disease physiologic indications for treatment are discussed and treatment is specifically outlined.

Nutritional needs and the effects of foods on gastrointestinal functions are outlined. The effects of indiscriminate use of drugs are pointed out. The indication and need for X-ray and laboratory studies are discussed with good perspective. Also, the indications for surgery and some of the complications resulting from surgery are presented.

It is felt that Doctor Andresen has compiled much practical and usable information of equal value for the student, general practitioner, and internist. His thoughts are presented clearly and concisely. This volume should find a convenient place on the bookshelf of the busy physician.

ELIHU S. WING, JR., M.D.

THE GENTLE LEGIONS by Richard Carter. Doubleday & Company, Inc., Garden City, N.Y., 1961. $4.50

THE GENTLE LEGIONS is a book which is both good and bad, with the bad outweighing the good. It is an interesting and engaging work for the first two-thirds. After that, because the author is carried away by his dislike of private enterprise, he becomes a poor reporter.

He begins well with a style both witty and charming, as he reports the backgrounds, purposes, and mechanics of the Red Cross, National Tuberculosis Association, American Heart Association, National Foundation for Infantile Paralysis, American Can-

cer Society, and others. Many questions are answered, and it seems to me that these voluntary health organizations are reported in general with fairness and clarity. So much for the first two thirds of THE GENTLE LEGIONS.

During the last third he really winds up and takes off in a bitter attack against the United Fund. Basically, he seems to feel that the Red Cross and other independent and voluntary health agencies which are on a relatively small scale, are permissible. However, according to the author, if a large scale effort is to be made to help many health and welfare agencies it should not be a united voluntary movement by individual Americans. It should be done only by the government — that is his preconceived conclusion.

He does not think much of private enterprise . . . in fact, he seems to dislike it intensely, especially if government is subservient to it. As a result, in reporting on the United Fund movement he writes from his own feelings, without documentation or specific references and proof.

Here is a book that starts out a winner and ends up a loser.

JOHN A. DILLON, M.D.

TENDON TRANSFERS IN ULNAR NERVE INJURIES by Armand D. Versaci. Plast. & Reconstruct. Surg. 26:500, 1960

Ulnar-nerve severance destroys the innervation to the intrinsic muscles of the hand, robbing it of its ability to perform the refined motions so necessary to the artisan and the skilled worker. The typical hand in ulnar palsy exhibits clawing of the ring and little fingers, loss of lateral finger motions, weakness of pinch and flattening of the transverse palmar arch. In high nerve lesions, terminal phalangeal flexion of the ring and little fingers may be affected.

Since the loss of motion varies with the pattern of innervation in any particular case, it is imperative to appraise the injury in terms of specific functional losses. Specific losses not recovered after otherwise successful re-innervation of the intrinsic muscles can be restored by tendon transfers. When definitive nerve repair is either unsuccessful or unduly prolonged, tendon transfers offer an immediate and functionally desirable solution to the problem. The most important intrinsic motions can be restored successfully without jeopardizing the basic attributes of the hand. The specific losses are considered individually, and tendon transfers for their correction suggested.

ANNUAL NARRATIVE REPORT
of the
WOMAN'S AUXILIARY OF THE RHODE ISLAND MEDICAL SOCIETY
1960 — 1961

MRS. RICHARD RICE, PRESIDENT, 1960-61

THE WOMAN'S AUXILIARY to the Rhode Island Medical Society has in every field of endeavor followed this year's theme advanced by our national president, Mrs. William Mackersie, *Accent Service to Preserve and Enhance the Heritage of American Medicine.* Each state has a situation peculiar unto itself, and, of course, governs its particular activities according to the needs and policies of its medical society. In so doing, we, at the close of another year, although a small state, feel the satisfaction of a big job well done. Statistically, to cover all required activities, we report the following:

A.M.E.F. Each organized county in Rhode Island raised money for this purpose. The state, by means of its annual dinner dance, covered the estimated donation. Individual use of the utility cards, plus the use of A.M.E.F. corsages, have us well over the estimated amount raised. Most important was the enthusiasm and response shown by the counties to the request of the state president for at least *one* "Fun-Fund-Raising Activity" for A.M.E.F. At our annual meeting Kent County received a certificate of merit for the largest amount donated and for 100% contribution. Our state A.M.E.F. chairman arranged to have a display at our annual meeting. Material sent from the national society was used and was quite effective. The total sum to be donated this year is not complete, but to date we have raised $450.00.

Bulletin

Our state Bulletin chairman at the first Board meeting collects money for subscriptions to the *Bulletin.* It is required that all state Board members subscribe. The county officers this year have been advised to do likewise. A new county just organized is striving for 100% subscription. The information derived from this booklet is absolutely beneficial to those in office and it would be well to require all members to subscribe.

On the state and county level we enjoy close relationship and co-operation with the Medical Society. We have three medical advisers and meet with them when necessary for advice. Our Auxiliary donates to the State Medical Society Benevolent Fund. Space is provided for us at the Medical Library for Auxiliary records and files and secretarial work such as announcements, fliers, etc. Our state program chairman has adhered closely to the policy of having both informative and entertaining programs planned for all meetings. Lectures by our own doctors, the use of films from National, plus the use of the skit *Four for Bridge* have been useful. Working closely with Hospitality and Membership chairmen, a very good attendance has been achieved. A summary of the various programs used by the counties was made and sent to the Eastern Regional program chairman, Mrs. George Ross, at her request, that she might have a display for the National Convention in June. We have found that a good program with membership participation (Skits and Fashion Shows, etc.) draws the most response and then with the captive audience, the more serious messages from Medicine can be included.

In response to a request for aid at the Diabetic Fair, sponsored by the Providence Medical Society, the state Auxiliary supplied nineteen volunteers to work at Pawtucket Memorial Hospital on November 16, 1960. Approximately 100 hours' work was given by these already busy doctors' wives. Working with the State Industrial Nurse director, our girls prepared ten thousand dri-paks to be distributed to factories for diabetic detection.

Safety

Early in the year our state president and safety chairman attended a planning session for a state conference on June 2, 1960, on Traffic Safety. Our state chairman, Mrs. Alexander Jaworski, was chosen to be secretary to this group. As an outgrowth of the Regional Traffic Safety Conference held in New York last fall, the Woman's Auxiliary to the Rhode Island Medical Society, working in conjunction with other women's organizations, planned a conference of Women's and Parents' organizations on Traffic Safety which was held at the Sheraton-Biltmore Hotel in Providence on Monday, September 26, 1960. This was in cooperation with the Rhode Island Council on Highway Safety.

The program had been planned to inform the organization members of the scope of the traffic accident problem, the need for traffic safety and what organizations can do about it. A guide for

community action developed by the National Safety Council and the Rhode Island Council on Highway Safety was presented.

The day's schedule began with registration at 9:00 A.M. A message from Governor Del Sesto was read at the start of the general session at 10:00 A.M. After a noon luncheon, there were four workshops at the afternoon session to complete the program.

Representing our Auxiliary was our safety chairman and secretary to this conference, Mrs. Alexander Jaworski, and our president, Mrs. Richard Rice, and her guest, Mrs. Joseph Chatigny, Eastern Regional Safety chairman. We were also represented at the Fifth Annual Governor's Conference on Traffic Safety on December 5, 1960, by our president-elect, Mrs. J. O'Brien. Our Safety chairman has been responsible for the presentation of safety programs to twenty-four organizations including hospital auxiliaries and P.T.A. groups. Aids used were "gem-packets, slides, lurking hazards in the home," posters regarding water safety (skiers and within boats), also posters concerning safety in the home (fire prevention, etc.) have been used. Because our state chairman of Safety is also president of two P.T.A. groups, excellent use of this material has been made — to say nothing of her TV appearance to be mentioned later.

This takes us into the field of voluntary service and philanthropic work in which our members are always actively engaged. A very nice example was voiced by the representative of one of our unorganized counties: "Lest you think we are completely idle down here — Dale Smith is chairman of the Barrington Cancer Crusade and I am residential gifts chairman. I mention this only because I think you should know that it is almost an overwhelming job lining up all the people we need to help us. I have over 200 in my part of it, and the doctors' wives responded just about 100% when I called them. I was really proud!" (Dale incidentally is editor of our state publication NEWSLETTER.) There are members-at-large, as in every other state, busily engaged in all *kinds* of volunteer work. The scope is really too vast to elaborate on.

We are proud of a member, Mrs. Russell R. Hunt, elected Rhode Island Mother of the Year for 1961. Our Auxiliary was proud to be represented at a luncheon in her honor on April 28, 1961.

Publicity — which we have not sought but have used as a means for better public relations, has been done in the usual manner, but with greater emphasis on television. A very special program was carried out this year by our Community Service chairman. Most of our important committees worked with the corresponding committee chairman from the Medical Society to further the cause of good public relations and inform the public of the aims and accomplishments and purpose of our Medical Society. Community service, a joint endeavor, certainly came to be when, through the courtesy of a state TV station, a public service TV series was presented on six half-hour morning spots in November. Judging by the verbal and written response, both to the station and to Auxiliary members, the project was well received by the public, indicating a good job had been done. We felt that TV is an invaluable vehicle for educating the public on health subjects as well as improving the doctor image in the eyes of the public.

1. *Civil Defense* — state Auxiliary CD chairman discussed home and family preparedness, using many booklets obtained through our state OCDM and table-top exhibits of home shelters obtained from our OCDM Region 1. A booklet on SHELTERS AND EQUIPMENT was sent out free in answer to all requests. A physician from the State Department of Health discussed *Emergency Medical Preparedness in Rhode Island*. The two worked together beautifully.

2. *Mental Health* — state Auxiliary Mental Health chairman and her husband, a psychiatrist, discussed facilities in Rhode Island and suggestions for maintaining good mental health, or preventing mental illness.

3. *Safety* — state Auxiliary Safety chairman discussed home, family and water safety, using a GEMS packet from National, and the home accident picture given out at Chicago Conference (Southern Union Gas Co.) Water Safety information from Red Cross. Also Safety slides used in P.T.A. talks, etc. The head of the Rhode Island Hospital Poison Control Center talked on this and used slides.

continued on next page

Mrs. James P. O'Brien, new president of the Woman's Auxiliary of the Rhode Island Medical Society, accepts the gavel from retiring president, Mrs. Richard Rice.
... PROVIDENCE JOURNAL-BULLETIN Photo

4. *Problems of the Aging*— hostessed by an Auxiliary member who is a former medical social worker. A physician specializing in geriatrics talked of the medical problems, and a staff consultant of the Rhode Island Council of Community Services presented the social and economic aspects. Our Auxiliary member offered the free booklet *Medicine's Blueprint for the New Era of the Aging* to write-ins.

5. *Health Careers* — Auxiliary members (medical technician, social worker, occupational therapist, dietitian, physical therapist) led by the Careers chairman discussed their specialties, showed pictures, and gave brief résumés. The chairman told of the Auxiliary Scholarships and others available.

6. *Community Health* — state Auxiliary chairman talked of TODAY'S HEALTH, showing sample copies, and the value of periodic checkups and keeping health records and getting to know your doctor. She used many booklets pertaining to these subjects from A.M.A. and offered free the individual A.M.A. Health Information card and the A.M.A. YOUR FAMILY HEALTH RECORD booklet. She also used health posters to show the value of starting health education early.

One physician reported on the Medical Society-sponsored Diabetic Fair. Another reported on facts and lessons learned during last summer's polio epidemic. These shows received the full approval of the Rhode Island Medical Society. *Mental Health* and *Civil Defense* were rerun on a Sunday morning (originals were all weekdays) and *Careers* was requested by several high schools and *Community Health* by hospitals for reruns, but unfortunately had been erased. They were all taped shows, but run through without rehearsals to give spontaneity to the shows.

It was generally felt that a definite public service was rendered and it was termed an "outstanding show by the TV station." As a result our Medical Society gained in good public relations. Our Community Service chairman has been authorized this year to represent our Auxiliary at the monthly meetings of the Rhode Island Council of Community Services, Inc.

Mental Health

Besides taking part in our TV series, our State Mental Health chairman arranged for our Board meeting and coffee hour at Butler Health Center, a leading psychiatric hospital in this state. This was followed by a tour conducted by the nursing service and was open to all Auxiliary members and interested friends. Our Auxiliary is represented at Mental Health Conferences, Butler Hospital Auxiliary, Charles V. Chapin Hospital and has contributed volunteer services by individuals as well as donating phonograph records, literature, magazines, etc., as the need arises. An ever-increasing demand for volunteers is being realized and should pose a challenge to our members for increased service in the future.

Civil Defense

Our Civil Defense activity has been kept well stimulated by our state chairman and by the Eastern Regional CD chairman who is a member and past president of our own state Auxiliary. She incidentally has the first *official* fall-out shelter built on the premises of an Auxiliary member in our state. However, many of our homes are ready for such an emergency. Our state chairman has attended meetings in Rhode Island and Massachusetts, received material such as home shelter model, films on home preparedness, posters and photographs, pamphlets on CD. She has distributed two hundred signed warning cards to P.T.A. groups and our Auxiliary. One hundred medicare clips have been distributed to our Auxiliary members. We are represented on the Woman's Advisory Council for Civil Defense here in Rhode Island. In addition to the TV program previously mentioned, our chairman has discussed informally ways of making the community aware of its part in civil defense.

On April 27 and 28, we as Auxiliary were requested to act as observers during the National "Operation Alert 1961." Co-operating with civil defense officials, members of our Auxiliary were stationed at marshaling yards all over the state including the control center. The equipment available and in good condition was that of locally owned fire and CD units and those purchased under the Federal Matching of Funds program.

By reports from Auxiliary members in various parts of the state, a complete picture of a state-wide readiness was gathered.

Legislation

A column called the *Legislative Corner* is written by the Legislative chairman for every issue of the Auxiliary *Bulletin*. This column is read by the entire state membership and keeps them informed on legislation on a state and federal level, particularly on medical legislation or that which affects the society. This information is gathered constantly through communications from the Rhode Island Medical Society, the A.M.A. *News*, the newspapers and literature sent from National. Literature sent to the Legislative chairman is distributed at Board meetings. We are a member of and attend all meetings of the Joint Legislative Council of Rhode Island.

Publications

Our state publication is called the NEWSLETTER. It is a budgeted expense from our treasury and goes to every state Auxiliary member, all state editors, the president and executive secretary of the Rhode Island Medical Society and to the national president, Publications chairman and executive secretary, three times a year.

Membership

Through the combined efforts of our Membership chairman, state organizer, and other board members, a new County Auxiliary was formed. A coffee hour was held for wives of members of the County Medical Society. The state Auxiliary president, Mrs. Rice, and even the Medical Society president, Doctor Mara, attended and discussed with this group the purpose of Auxiliary, which formed the nucleus of interest. Later at the call of the county representative, Mrs. Tartaglino, another meeting of these wives was held and the group decided to organize on January 23, 1961. Out of thirty-five eligible members, there are now thirty paid Auxiliary members. We are proud and pleased to have this new constituent Auxiliary added to our state organization. The state has a total membership of five hundred eighty-five members with three hundred thirty-eight members-at-large.

Health Careers

This committee represents a panel made up of doctors' wives representing the following careers: dietitian, medical technologist, physiotherapist, occupational therapist, medical social worker. Each member of the panel is a qualified member of her profession. An informal panel presentation of these careers is given and very well received by students at the High School level. After each presentation, there were brief conferences with any students interested. Pamphlets were made available to all students for each career. The pamphlets were very popular with the students. This year two $300.00 scholarships in these health fields are to be awarded and by special request from this committee an additional donation will be given to the University of Rhode Island Scholarship Fund.

Also our Nurse Scholarship chairman will award the Lillian M. Harris Scholarship to two young student nurses. Using the rotating plan among the five eligible schools of nursing in Rhode Island we gave one scholarship to Pawtucket Memorial Hospital and one to Roger Williams Hospital School of Nursing. Both schools were very grateful to receive this aid. An additional amount was given to supplement one scholarship because of a particularly deserving case.

concluded on next page

Sunday...

IN THE COUNTRY

October 15, 1961

FAMILY DAY

for the

Members of the

Rhode Island

Medical Society

and the

Woman's Auxiliary

at the

ANDERSON FARM

Coventry

Rhode Island

Check the date!

Details later!

The Doctors' *Benevolent Fund* received $375.00 from the Auxiliary this year. The additional from an accumulated sum which was decided to be distributed to this and all the above-mentioned community services plus A.M.E.F. Most of the funds raised comes from our Ways and Means committee by means of a state dinner dance which once again successfully supplied the estimated necessary amount.

Over and beyond the statistical report of accomplishment is the sense of unity coming from an organized group of women working together for a common cause.

Guided by our state Medical Society locally on political issues, we have not "trod where Saints fear to tread," but have at their request left these subjects for the Medical Society to handle. By accentuating the positive, by informing the public and providing programs suggested by the A.M.A., we have tried to make it known that medical people want "to help those who need help." We have emphasized that the public, desiring medical care under a social plan, are risking the loss of freedom of choice. What good citizen doesn't value his right to vote? And thus it follows, he should value the right of having the service of a physician of his own choosing. In this year of work, we were ever mindful of striving to preserve the heritage of American medicine.

1960-1961 — Represented at the following:

1. Joint Legislative Council of Rhode Island
2. Rhode Island Conference of Social Workers
3. Governors' Conference on Traffic Safety
4. Women's and Parents' Conference on Traffic Safety
5. Rhode Island Council on Highway Safety
6. The Rhode Island Council of Community Services, Inc.
7. The Rhode Island Woman's Advisory Council for Civil Defense
8. Women's Civil Defense Council — Region 1 in Topsfield, Mass.
9. The Connecticut Conference on Homemaker Service

Contributions Made from Funds Raised this Year

1. Nurse scholarship, Pawtucket Memorial Hospital	$ 225.00
2. Nurse scholarship, Roger Williams Hospital	160.00
3. Paramedical Careers Scholarship	300.00
4. Paramedical Careers Scholarship	300.00
5. Paramedical Careers Scholarship	50.00
6. Doctors' Benevolent Fund, Rhode Island Medical Society	375.00
7. A.M.E.F. (National)	450.00
Total	$1,860.00

WOMAN'S AUXILIARY TO THE RHODE ISLAND MEDICAL SOCIETY

OFFICERS AND COMMITTEES, 1961-1962

Officers

President.....Mrs. James P. O'Brien, 85 Woodland Road, Woonsocket, PO 2-3301
President-Elect.....Mrs. Angelo Archetto, 964 Cranston Street, Cranston, WI 2-7070
Vice-President.....Mrs. Lester L. Vargas, 20 Laurel Court, Providence, PL 1-5484
Recording Secretary.....Mrs. Edward Damarjian, 22 Haliburton Road, East Providence, GE 8-5452
Corresponding Secretary.....Mrs. Nathaniel D. Robinson, 17 Dexterdale Road, Providence, JA 1-0508
Treasurer.....Mrs. Donald F. Larkin, 54 Kirby Avenue, Warwick, RE 7-4949
Assistant Treasurer.....Mrs. Lee G. Sannella, 18 Fairview Avenue, Cranston, WI 1-3121

Appointed Officers

Historian.....Mrs. J. Murray Beardsley, 90 Congdon Street, Providence, PL 1-9223
Parliamentarian.....Mrs. Herbert E. Harris, 112 Francis Street, Providence, DE 1-6834

Directors

Bristol.....Mrs. Henry B. Fletcher, 6 Quincy Adams Road, Barrington, CH 5-2530
Kent.....Mrs. Richard R. Dyer, 127 Beacon Avenue, Warwick Neck, RE 7-2148
Newport.....Mrs. Alfred M. Tartaglino, 75 Pelham Street, Newport, VI 7-5301
Pawtucket.....Mrs. John J. Cunningham, 18 Anawan Road, Pawtucket
Providence.....Mrs. Robert V. Lewis, 17 Woodbury Street, Providence, DE 1-2920
Washington.....Mrs. John D. Pinto, Shelter Harbor, Westerly, FA 2-7978
Woonsocket.....Mrs. Euclide L. Tremblay, Pound Hill Road, N. Smithfield, PO 9-4477
Advisory Member.....Mrs. Mark A. Yessian, 233 Miantonomo Drive, Warwick, HO 3-8255
Advisory Member.....Mrs. Richard Rice, 31 King Philip Circle, Warwick, HO 3-8495

Committee Chairmen

A.M.E.F......Mrs. Joseph C. Kent, Johnson Road, Foster, EX 7-7728
Bulletin.....Mrs. Philip J. Morrison, 168 Woodland Road, Woonsocket, PO 9-6410
By-laws.....Mrs. Thomas F. Head, 31 Elmhurst Avenue, Providence, UN 1-6267
Civil Defense.....Mrs. Raul Nodarse, 1149 Hartford Avenue, Johnston, TE 1-3144
Community Service.....Mrs. Michael E. Scala, 65 Hoyt Avenue, E. Providence, GE 8-4429
Health Careers.....Mrs. Herbert F. Hager, 42 Kensington Road, Cranston, ST 1-9192
Hospitality.....Mrs. Richard E. Haverly, 341 Cole Avenue, Providence, PL 1-5720
Legislation.....Mrs. Arthur B. Kern, 610 East Avenue, Pawtucket, PA 3-8877
Membership.....Mrs. Daniel D. Young, 134 Francis Street, Providence, PL 1-9292
Mental Health.....Mrs. Patrick F. O'Mahony, 33 Adalaide Avenue, Barrington, CH 5-9079
Program.....Mrs. Carl V. Anderson, 584 Cowesett Road, Warwick, TU 4-1523
Publications.....Mrs. Bruce W. Smith, 136 County Road, Barrington, CH 5-7360
Publicity.....Mrs. Ira H. Anjoorian, 20 Pensankee Avenue, N. Providence, EL 3-3635
Reports.....Mrs. Stanley D. Simon, 52 Ridge Street, Pawtucket, PA 5-0575
Safety.....Mrs. Francis P. Vose, Old River Road, Manville, PO 9-4010
Scholarships.....Mrs. Arthur E. Hardy, 901 Narragansett Parkway, Warwick, HO 1-8902
Sesquicentennial.....Mrs. Mark A. Yessian, 233 Miantonomo Drive, Warwick, HO 3-8255
Ways and Means.....Mrs. Thomas Perry, Jr., 631 Angel Street, Providence, PL 1-8941
Ways and Means.....Mrs. Arno Kiiss, 31 Annette Avenue, Woonsocket, PO 2-3120

SCANNING THE MEDICAL LITERATURE

Abstracts of Papers Written by Rhode Islanders

THE IMPACT OF PARENTS ON THE GROWTH OF EXCEPTIONAL CHILDREN. Eric Denhoff. J. Exceptional Child. 26:271, 1960.

This article summarizes the reasons for the feelings of parents regarding their handicapped children. Data are from studies at Meeting Street School with children who are handicapped by cerebral palsy and related disorders. It is felt that parents of handicapped children have the same basic feelings for their children as parents of normal children. Early pregnancy attitudes based on fears or misconceptions of handicap greatly influence a mother's feelings for her child.

Parents who have distorted precepts about childhood behavior have a strong adverse impact on their child's future adjustment. In reverse, parents who are warm and accepting, and will accept professional advice, can favorably influence their child's development when physical and intellectual aspects in early childhood appear dim. Therefore, emphasis must be made in treating the family as well as the child in the habilitation of chronic disabilities of childhood. The parents must realize that, although a handicapped child can never achieve the same excellence in performance as an unhandicapped child, psychological factors can often influence more ultimate adjustment than can the degree of handicap.

ERIC DENHOFF, M.D.

DIHYDROVITAMIN K_1 BIPHOSPHATE IN BISHYDROXYCOUMARIN INDUCED HYPOPROTHROMBINEMIA. Milton Shoshkes and Mario Tami, J. Lab. & Clin. Med. 56:21, 1960.

Dihydrovitamin K_1 biphosphate, a water soluble salt, has been reported to be an effective antagonist to drug induced hypoprothrombinemia, comparable to, if not superior to, oil soluble vitamin K_1. This water soluble salt was administered to hospitalized patients rendered hypoprothrombinemic with bishydroxycoumarin in doses varying from 5 to 50 mg. orally, 10 to 50 mg. intravenously, 50 mg. intramuscularly, and 50 mg. subcutaneously. Prothrombin times observed over 24 hours demonstrated this vitamin to be quite ineffective when comparisons to a control group were made. A definite positive effect greater than the control could be found only after 50 mg. intravenously or subcutaneously was given; all other dose ranges and routes were lacking in prothrombin time response, failing to confirm any therapeutic effectiveness with dose ranges comparable to those recommended for phytonadione by oral and parenteral routes.

MARIO TAMI, M.D.

CAPILLARIES OF NORMAL AND DISEASED BREAST. Herbert Fanger and Barbara Barker, A.M.A. Arch. Path. 69:67, 1960.

The capillary vasculature of breast tissue can be demonstrated by the histochemical reactions for alkaline phosphatase and peroxidase in thick sections of tissue. There is a complex network of capillaries surrounding the ducts and ramifying in the lobules of normal breast. In benign lesions of the breast, the capillaries have a similar distribution, but their arrangement is altered, corresponding to the distortion of the epithelium.

The alkaline phosphatase technique shows a diminished capillary vasculature in the connective tissue surrounding large cysts in fibrocystic disease, in florid adenosis, and in carcinoma. There is a possibility that the paucity of capillaries demonstrated by this procedure may be due to altered metabolism of capillary endothelial cells.

PHOSPHORYLASE AND AMYLO-1, 6-GLUCOSIDASE IN BREAST TISSUE. Herbert Fanger and Barbara Barker. J. Nat. Cancer Inst. 24:691, 1960.

Phosphorylase and amylo-1, 6-glucosidase catalyze the reversible reaction glucose-1-phosphate to glycogen. Breast tissue abounds in both enzymes, in contrast to apocrine sweat glands, which have none. It had previously been suggested that the secretory portion of the breast consisted of modified sweat-gland tissue. This work suggests that these two tissues have a profoundly different metabolic activity.

EMERGENCY RENAL SURGERY IN THE NEWBORN INFANT. Arnold Porter and Ernest K. Landsteiner. New England J. Med. 263:1, 1960.

Approximately fifty per cent of abdominal masses

in the newborn infant are of urinary tract origin. Most of these are in the kidney and may constitute a surgical emergency because of distressing symptoms or the possibility of malignancy.

Physical examination and laboratory studies including intravenous urography through the preoperative intravenous cutdown aid in establishing the diagnosis.

Surgical emergencies of the kidney in the newborn include renal tumor, solitary renal cyst, unilateral multicystic kidney disease, renal infarction, and ureteropelvic obstruction.

Renal Tumor

Malignant renal tumors are rare at birth and must be differentiated from malignant neuroblastomas and retroperitoneal teratomas.

Solitary Renal Cyst

Solitary renal cysts in the newborn are similar to those found in older children and adults and should be locally excised. They are often associated with other urological anomalies.

Unilateral Multicystic Kidney Disease

Unilateral multicystic kidney disease is a separate entity to be differentiated from bilateral polycystic kidneys. The kidney is practically replaced by a cluster of varying size cysts and the ureter is usually absent or atretic. Symptoms are few and a unilateral flank mass is usually picked up on routine examination. Nephrectomy is the only treatment.

Renal Infarction

Renal infarction secondary to renal-vein thrombosis may be unilateral or bilateral and is usually associated with dehydration from other causes. The diagnosis should be suspected when a flank mass, hematuria, pyuria, oliguria fever, leukocytosis, shock, and a hemolytic type of jaundice are found in an ill baby. Nephrectomy is indicated in unilateral disease and supportive therapy and anticoagulants are reserved for bilateral disease.

Ureteropelvic Obstruction

Ureteropelvic obstruction due to intrinsic or extrinsic causes is a common anomaly. Gastrointestinal symptoms and/or respiratory embarrassment secondary to the large mass may mark the situation as an emergency.

The surgical procedure of choice depends upon the etiology of the obstruction, the amount of kidney tissue present, and the status of the opposite kidney. Usually, if large enough to cause symptoms in the neonatal period, nephrectomy will be required.

EDITORIAL: THE PRESENT STATUS OF PERIPHERAL ARTERIAL RECONSTRUCTION FOR ARTERIOSCLEROSIS OBLITERANS. Seebert J. Goldowsky, M.D., Ann. Int. Med. 52:268, 1960.

The emphasis in this review is on occlusive disease as contrasted with aneurysm, and on the peripheral ileo-femoro-popliteal vessels rather than the more central aorto-iliac system. Clinically this represents the essence of the major problem in peripheral arteriosclerosis obliterans.

The relatively large series of cases amenable to surgery accumulated in the vascular centers is not a true indication of the incidence of suitable cases in a general medical or surgical practice, or in a community general hospital accepting run-of-the-mill admissions.

It must be concluded on the basis of present evidence that best results can be expected in bypass shunts of micro-crimped dacron or teflon or in thromboendarterectomy, performed in cases with adequate run-off. Conditions suitable for surgery will be present in some 25 to 60% of cases. Immediate restoration of circulation can be expected in somewhere between 65 and 95% of operated cases, while late failure will occur in 10 to 80% of those having immediate success. The evidence is still equivocal, and the paucity of reports and the slowness with which they are appearing would suggest that success in this area is still of a limited nature.

INJECTION THERAPY OF GRANULOMA ANNULARE. Arthur B. Kern and Bencel L. Schiff. A.M.A. Arch. Dermat. 81:969, 1960

Treatment for this cutaneous disorder of unknown etiology has included a great variety of measures. This multiplicity of therapeutic approaches is evidence of the fact that nothing specific has been available. Accordingly, with the introduction of intralesional injection of hydrocortisone it was decided to utilize this method in the treatment of granuloma annulare.

The first patient treated in this manner showed complete clearing of all lesions despite the fact that he had previously failed to benefit from a great many forms of therapy. Some of the lesions of our second patient were injected with normal saline solution, to act as a control. Both the test and control areas returned to normal. The next four patients were treated by intralesional injections of normal saline, procaine, lidocaine or sterile distilled water. Involution of the tumors was induced in three of the cases and in the fourth there was improvement.

In summary, although its mode of action is not as yet understood, intralesional injections with relatively innocuous agents, such as normal saline or lidocaine, is another tool to be utilized in the treatment of granuloma annulare.

Check the date . . .

Monday, Sept. 11, 1961

SPORTS INJURY CONFERENCE

1:00 P.M. to 9:30 P.M.

at

Providence College

Under the Auspices of the

Committee on the Prevention and Treatment of Athletic Injuries

of the

Rhode Island Medical Society

Conference open to all Physicians in Rhode Island, Secondary School Coaches, Trainers, Athletic Directors and Allied Personnel

INDEX OF ADVERTISERS